

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2

2 6 2 2 8

REG. NO.

1- FOR
STATE
REGISTRAR

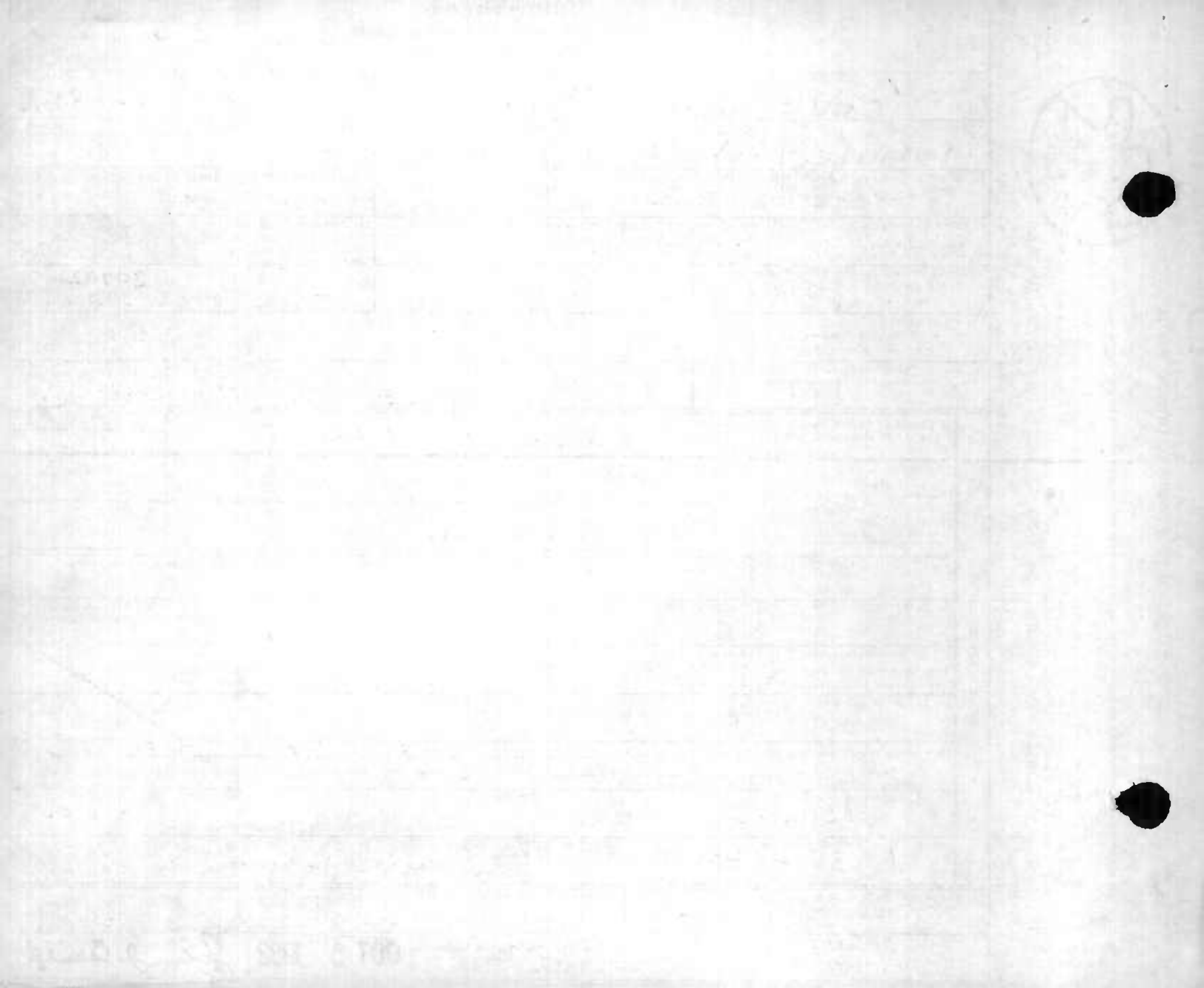
1. DECEASED NAME (TYPE OR PRINT) <i>Emily Mirrikee SPAAR</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10 1 82</i>			2b. HOUR <i>3:50 P.M.</i>					
3 SEX <i>Female</i>		4 RACE <i>White</i>		5 DATE OF BIRTH MONTH DAY YEAR <i>5 21 1895</i>		6 AGE (IN YEARS LAST BIRTHDAY) <i>87</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Louisiana</i>		7b CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.					
10 CITY OR TOWN OF DEATH <i>Baltimore City</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Lutheran Hospital</i>				12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Book Keeper</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Waldhorn Co.</i>			
13a STATE <i>MD.</i>			13b COUNTY <i>Montgomery</i>		13c CITY OR TOWN <i>Silver Spring</i>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET ADDRESS <i>20902 10105 McKenney Ave. Apt. 203</i>		
14 FATHER'S NAME FIRST MIDDLE LAST <i>John Albert Spaar</i>			15. MOTHER'S MAIDEN NAME MIDDLE <i>Caroline Schulte</i>			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>Yes WWI</i>				16b. SOCIAL SECURITY NO. <i>434-07-0508</i>	
17. INFORMANT <i>Edmund M. Buras, Jr.</i>			ADDRESS <i>824 Burnt Mills Ave Silver Spring MD.</i>								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <i>4140</i> IMMEDIATE CAUSE (a) <i>CARDIO RESPIRATORY ARREST</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
DUE TO, OR AS A CONSEQUENCE OF (b) <i>CONGESTIVE HEART FAILURE</i>											
DUE TO, OR AS A CONSEQUENCE OF (c) <i>ATHEROSCLEROTIC HEART DISEASE</i>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <i>19</i>			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>9. 26.</i> , 19 <i>82</i> , to <i>10. 1.</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>10. 1.</i> , 19 <i>82</i> , and that (in my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>N.S. ASHOK</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED <i>10. 1. 82</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>N.S. ASHOK</i>			22e. ADDRESS <i>Lutheran Hospital</i>								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Cremation</i>			23b. DATE <i>10-5-82</i>			23c. NAME OF CEMETERY OR CREMATORY <i>Westview Memorial Park</i>			23d. LOCATION CITY OR TOWN COUNTY STATE <i>Catonsville Balto. MD.</i>		
24 FUNERAL DIRECTOR NAME <i>Loring Byers Funeral Directors, Inc.</i> ADDRESS <i>8728 Liberty Road Randallstown, MD. 21133</i>						25a. DATE RECEIVED BY REGISTRAR <i>OCT 5 1982</i>			25b. REGISTRAR'S SIGNATURE <i>John J. Canfield</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP



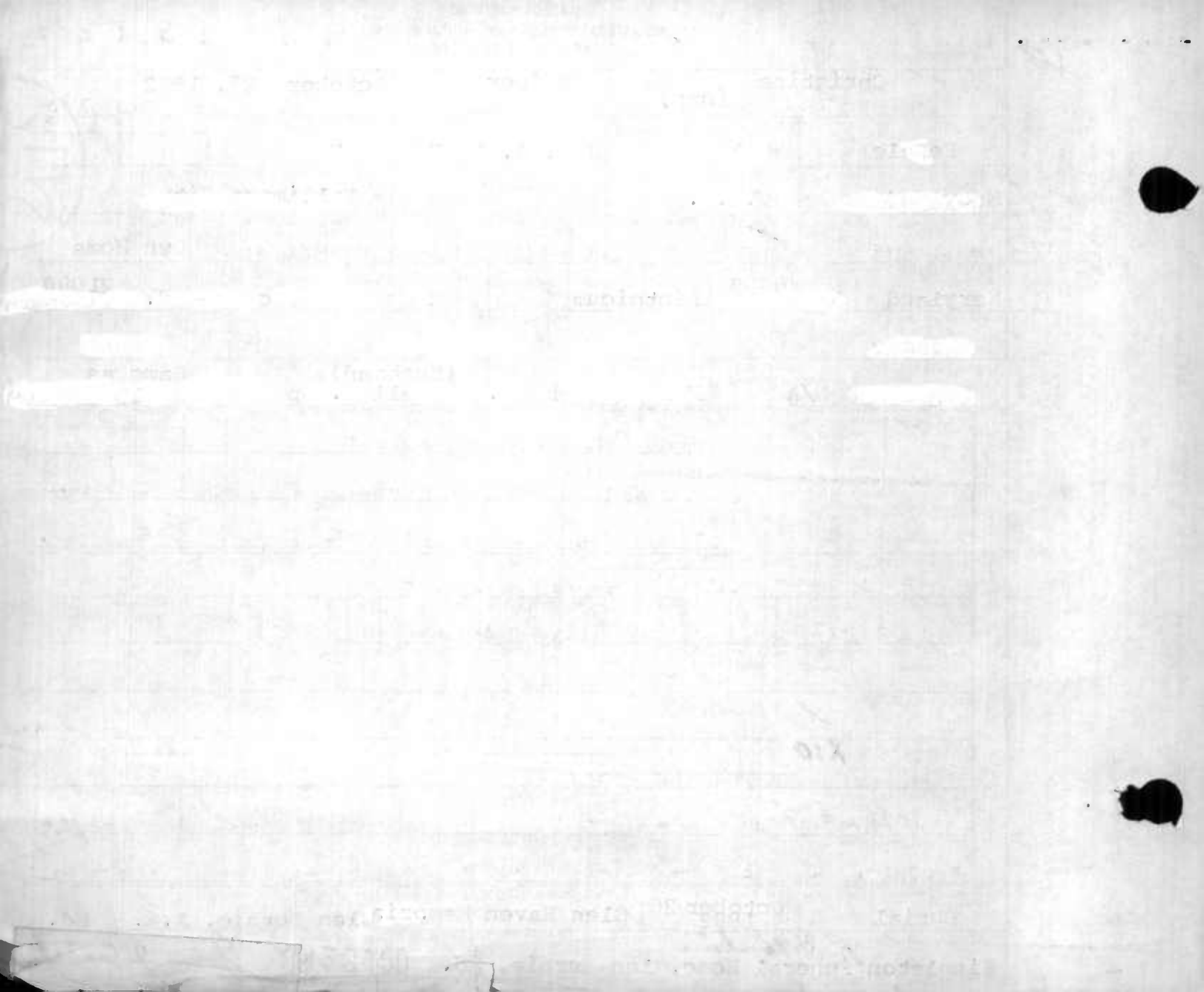
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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		2. DATE OF DEATH		3. TIME OF DEATH		4. HOUR		5. MINUTE	
1. DECEASED NAME (TYPE OR PRINT)		2. DATE OF DEATH		3. TIME OF DEATH		4. HOUR		5. MINUTE	
Christine (nmn) SPICER		October 23, 1982		OCT. 23, 1982		7 A.M.			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR	
Female		White		Jan. 6, 1907		75 YRS.		MONTHS DAYS HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH		12. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland		U.S.A.				Baltimore City		MD.	
13. CITY OR TOWN OF DEATH		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		16. KIND OF BUSINESS OR INDUSTRY		17. Own Home	
BALTIMORE		SOUTH BALTIMORE GEN. HOSP.		HOUSEWIFE					
18. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		19. CITY OR TOWN		20. INSIDE CITY LIMITS?		21. STREET ADDRESS		22. 21090	
Maryland		Anne Arundel		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		6410 Orchard Rd.			
23. FATHER'S NAME		24. MOTHER'S MAIDEN NAME		25. INFORMANT (Husband)		26. ADDRESS		27. Same as #13	
George		Matilda		Mr. Russell N. Spicer					
28. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		29. SOCIAL SECURITY NO.		30. INFORMANT (Husband)		31. ADDRESS		32. Same as #13	
No		N/A		Mr. Russell N. Spicer					
33. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART I. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) <u>CARDIO-RESPIRATORY ARREST</u>									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
(b) <u>BILATERAL BRONCHOPNEUMONIA</u>									
DUE TO, OR AS A CONSEQUENCE OF									
(c) <u>TERMINAL LUNG CANCER</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
<u>FRACTURE LEFT FEMUR - REDUCED</u>									
34. DATE OF OPERATION		35. CONDITION FOR WHICH OPERATION WAS PERFORMED		36. AUTOPSY?		37. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		38. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
OCT. 13, 1982		FRACTURE LEFT FEMUR		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
39. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		40. TIME OF INJURY (HOUR (A.M.) MONTH DAY YEAR)		41. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)		42. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		43. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
		P.M. 10 23 1982				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
44. INJURY OCCURRED		45. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		46. LOCATION		47. CITY OR TOWN		48. COUNTY	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		HOME		6410 ORCHARD		LINTHICUM		MARYLAND	
49. I certify that (I) (this hospital) attended the deceased from <u>10/13/82</u> to <u>10/23/82</u> , that (I) (we) lost saw the deceased alive on <u>10/23/82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
50. SIGNATURE		51. DEGREE		52. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		53. DATE SIGNED		54. 10/23/82	
Fluante Richard Mancas									
55. PHYSICIAN'S NAME (TYPE OR PRINT)		56. ADDRESS		57. NAME OF CEMETERY OR CREMATORY		58. LOCATION		59. CITY OR TOWN	
FLUANTE RICHARD MANCAS		SOUTH BALTIMORE GEN. HOSPITAL		Glen Haven Mem. Pk.		Glen Burnie, A.A.		Md.	
60. BURIAL, CREMATION, REMOVAL (SPECIFY)		61. DATE		62. NAME OF CEMETERY OR CREMATORY		63. LOCATION		64. CITY OR TOWN	
Burial		October 26, 1982		Glen Haven Mem. Pk.		Glen Burnie, A.A.		Md.	
65. FUNERAL DIRECTOR NAME		66. ADDRESS		67. DATE REC'D. BY REGISTRAR		68. REGISTRAR'S SIGNATURE		69. 10/26/1982	
Singleton Funeral Home, Glen Burnie, Md.				OCT 26 1982		John J. Carver			

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR			
SPIKLOSER ALBERT A. SPIKLOSER				10 17 82				2 ⁵⁰ AM			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
MALE		WHITE		6 30 24		58		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
MARYLAND		USA				BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (INDICATE ONLY MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE		SINAI HOSPITAL				MERCHANT		RETAIL			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
MARYLAND		BALTO.		BALTIMORE		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		4 CANDLEMAKER CT. #21208			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
JOSEPH W. SPIKLOSER				BESSIE POLSKY							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) (IF YES, GIVE WAR OR DATES)				16b. SOCIAL SECURITY NO.		17. INFORMANT					
NO				218-14-5896		MRS. ESTELLE SPIKLOSER APT. 205 4 CANDLEMAKER CT. BALTO., MD 21208					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) <u>Acute MI</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>severe CAD - inoperable tripple vessel disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>Oct 17</u> , 19 <u>82</u> , to <u>Oct 17</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>Oct 17</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE G. Gillian 8/10/3						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-17-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G. GILLIAN, M.D.						22e. ADDRESS SINAI HOSP. - BALTO., MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 18, 1982		23c. NAME OF CEMETERY OR CREMATORY SHAAREI ZION		23d. LOCATION CITY OR TOWN COUNTY STATE ROSEDALE BALTO. MD			
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR OCT 20 1982		25b. REGISTRAR'S SIGNATURE John J. Conner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 6 2 3 1 REG. NO.					
1. DECEASED NAME (TYPE OR PRINT) Gerwazzia SPIOCH				2a. DATE OF DEATH MONTH DAY YEAR Oct 22, 1982				2b. HOUR 12:30 M	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 6 16 10		6. AGE (IN YEARS LAST BIRTHDAY) 72 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
12. CITY OR TOWN OF DEATH BALTIMORE		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CITY Hospital				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOMEMAKER		15. KIND OF BUSINESS OR INDUSTRY	
16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 17a. STATE MARYLAND 17b. CITY OR TOWN BALTIMORE		18. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		19. STREET ADDRESS 3413 YARDLEY DR.					
20. FATHER'S NAME FIRST MIDDLE LAST ADAM KOZLOWSKI				21. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ANNA GROCKI					
22. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO				23. SOCIAL SECURITY NO. 218 109 411		24. INFORMANT ADDRESS FRANCES STANKOWSKI 3413 YARDLEY DR.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Pulmonary Arrest 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) MI, Stroke DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from Oct 21, 1982, to Oct 22, 1982, that (I) (we) last saw the deceased alive on Oct 21, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robin Fintel MD				DEGREE				22c. DATE SIGNED Oct 22, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Robin Fintel MD				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/25/1982		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MD.			
24. FUNERAL DIRECTOR NAME RAYMOND L. KACZOROWSKI				25a. DATE REC'D. BY REGISTRAR OCT 26 1982		25b. REGISTRAR'S SIGNATURE John J. Carver			

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MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 2 6 2 3 2					
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CLAUDIA SPRUILL				2a. DATE OF DEATH MONTH DAY YEAR OCT. 5, 1982				2b. HOUR 11:30 M	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 9 02		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 80 YRS.		7. IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN.	
7. PLACE OF BIRTH (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF SUCH INSTITUTION) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland				13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 228 Silver Court	
14. FATHER'S NAME FIRST MIDDLE LAST Steven Skinner				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 212-26-0057		17. INFORMANT ADDRESS Elnora Knight 2021 E. 30th St. 21218			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: 1539 Metastatic colon Ca IMMEDIATE CAUSE (a) Metastatic colon Ca DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21a. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (1) (this hospital) attended the deceased from 10/1 19 82 to 10/5 19 82 , that (1) (we) lost saw the deceased alive on 10/5 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did not) view the body after death.									
22b. SIGNATURE Eric Johnson				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10/5/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eric Johnson				22e. ADDRESS Johns Hopkins Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 10/11/82		23c. NAME OF CEMETERY OR CREMATORY cedar Hill Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue				25a. DATE REC'D. BY REGISTRAR OCT 8 1982		25b. REGISTRAR'S SIGNATURE John J. Conner			

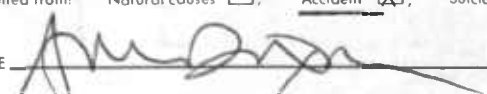

3-200

of 80 EAD

10005

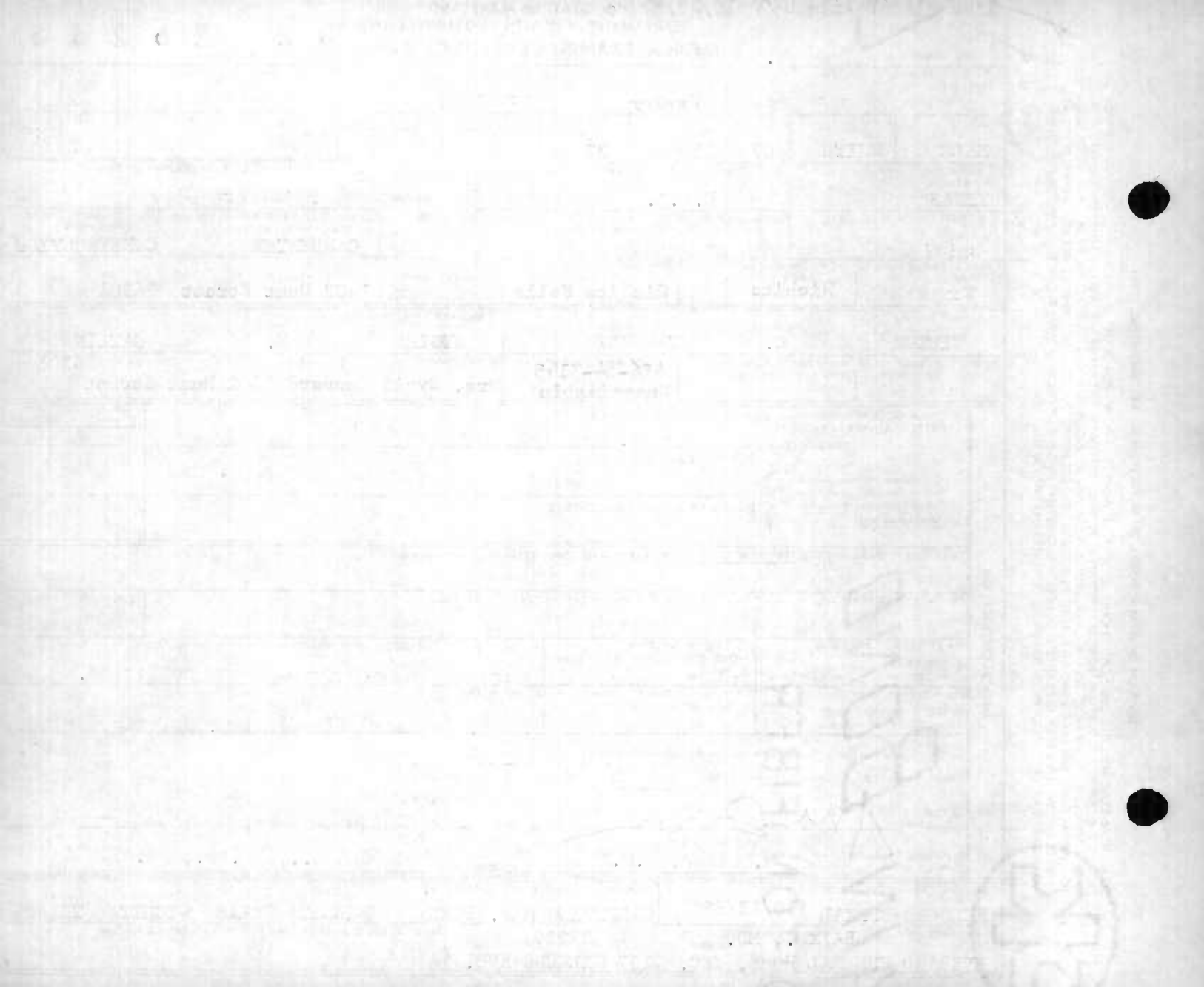


Y.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST GREGORY Parker STAMPFLI						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 8 19 82			2b. HOUR M 6:45 P M				
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 07 31 50		6. AGE (IN YEARS) (LAST BIRTHDAY) MONTHS DAYS HOURS MIN 32 YRS.		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 8 19 82		7d. HOUR M 6:45 P M			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) TEXAS				7b. CITIZEN OF WHAT COUNTRY? U.S.A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CARPENTER				12b. KIND OF BUSINESS OR INDUSTRY CONSTRUCTION	
13a. STATE Texas						13b. CITY OR TOWN Wichita		13c. CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 1402 Hunt Street 76301			
14. FATHER'S NAME FIRST MIDDLE LAST VICTOR C. STAMPFLI						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SYBIL M. GATLIN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. 456-84-3145 Unavailable		17. INFORMANT ADDRESS Mrs. Sybil Leonard 1402 Hunt Street 76301					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8122 IMMEDIATE CAUSE (a) Thoraco-abdominal trauma DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR MONTH DAY YEAR 5:37 P.M. 10-8- 19 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Operator of motorcycle/truck collision.							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road		21f. LOCATION CITY OR TOWN COUNTY STATE US Rt. 1 near Ruffs Mill Rd., Bel Air, Harford, Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE 						TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 10-9-82			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.						ADDRESS 111 Penn St., Balto., Md. 21201							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) REMOVAL/BURIAL				23b. DATE 10/13/82		23c. NAME OF CEMETERY OR CREMATORY CRESTVIEW MEM. PARK				23d. LOCATION CITY OR TOWN COUNTY STATE WICHITA FALLS WICHITA TEXAS			
24. FUNERAL DIRECTOR NAME BALTO., MD. 21229						25a. DATE REC'D. BY REGISTRAR OCT 13 1982						25b. REGISTRAR'S SIGNATURE 	
HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.													

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 2 3 4

REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) BUESSEE STANDRIDGE		2a. DATE OF DEATH MONTH 10 DAY 04 YEAR 82		2b. HOUR 1240 A.M.	
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH 11 DAY 11 YEAR 21		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) GEORGIA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINTENANCE		12b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1117 SHERWOOD AVE		14. FATHER'S NAME FIRST Jasper A. MIDDLE STANDRIDGE LAST STANDRIDGE		15. MOTHER'S MAIDEN NAME FIRST Pecola MIDDLE JARRET LAST JARRET			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 254-24-1032		17. INFORMANT HOSPITAL RECORD		ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-RESPIRATORY ARREST 1539 DUE TO, OR AS A CONSEQUENCE OF (b) UPPER GASTRO INTESTINAL BLEEDING Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) CARCINOMA OF COLON		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5-10 MINUTES 36 days 7 months
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PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION 8/28/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED UPPER G.I. BLEED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Aug 27 , 19 82 , to OCT 4 , 19 82 , that (I) (we) last saw the deceased alive on OCT 4 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE James J. Damalowski				DEGREE MD		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAMALOWSKI				22e. ADDRESS 22 S. Greene St. BALT 21201			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-7-82		23c. NAME OF CEMETERY OR CREMATORY Parkwood Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR John C. Miller Inc-6415 Belair Rd.-21206				25. DATE REC'D. BY REGISTRAR OCT 5 1982		25. REGISTRAR'S SIGNATURE John J. [Signature]	

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 2 3 5

FOR
1- STATE
REGISTRAR

REG. NO.

DECEASED NAME (TYPE OR PRINT) BESSIE S STANMORE			7a. DATE OF DEATH MONTH DAY YEAR 10 2 82		7b. HOUR 5 P M
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 08 06 98	6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE MD	7b. CITIZEN OF WHAT COUNTRY? U.S.-A	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MARYLAND HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED		12b. KIND OF BUSINESS OR INDUSTRY -
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY BALTIMORE	13c. CITY OR TOWN BALTIMORE	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 1735 Pulaski St
14. FATHER'S NAME FIRST MIDDLE LAST GEORGE NMI STEVENS		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MAGGIE NMI SNEAD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) UNKNOWN		16b. SOCIAL SECURITY NO. 217-096257			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory and Cardiac Arrest 4960 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Severe Chronic Obstructive Pulmonary Disease years DUE TO, OR AS A CONSEQUENCE OF (c) _____					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 30-45 min.
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a. DATE OF OPERATION 9-23-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED placement of tracheostomy for long term on Respirator.		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22. I certify that (a) (this hospital) attended the deceased from 9-10 , 19 82 , to 10-2 , 19 82 , that (a) (we) last saw the deceased alive on 10-2 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.					
22a. SIGNATURE Dr. Richards MD		DEGREE		22c. DATE SIGNED 10-2-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-7-82		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.	
23d. LOCATION (CITY OR TOWN) COUNTY STATE Balto. Co. Md		24. FUNERAL DIRECTOR NAME Joseph L. Russ		25a. DATE REC'D. BY REGISTRAR OCT 4 - 1982	
25b. REGISTRAR'S SIGNATURE John J. Carver					

FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH8 2 2 6 2 3 6
REG. NO.

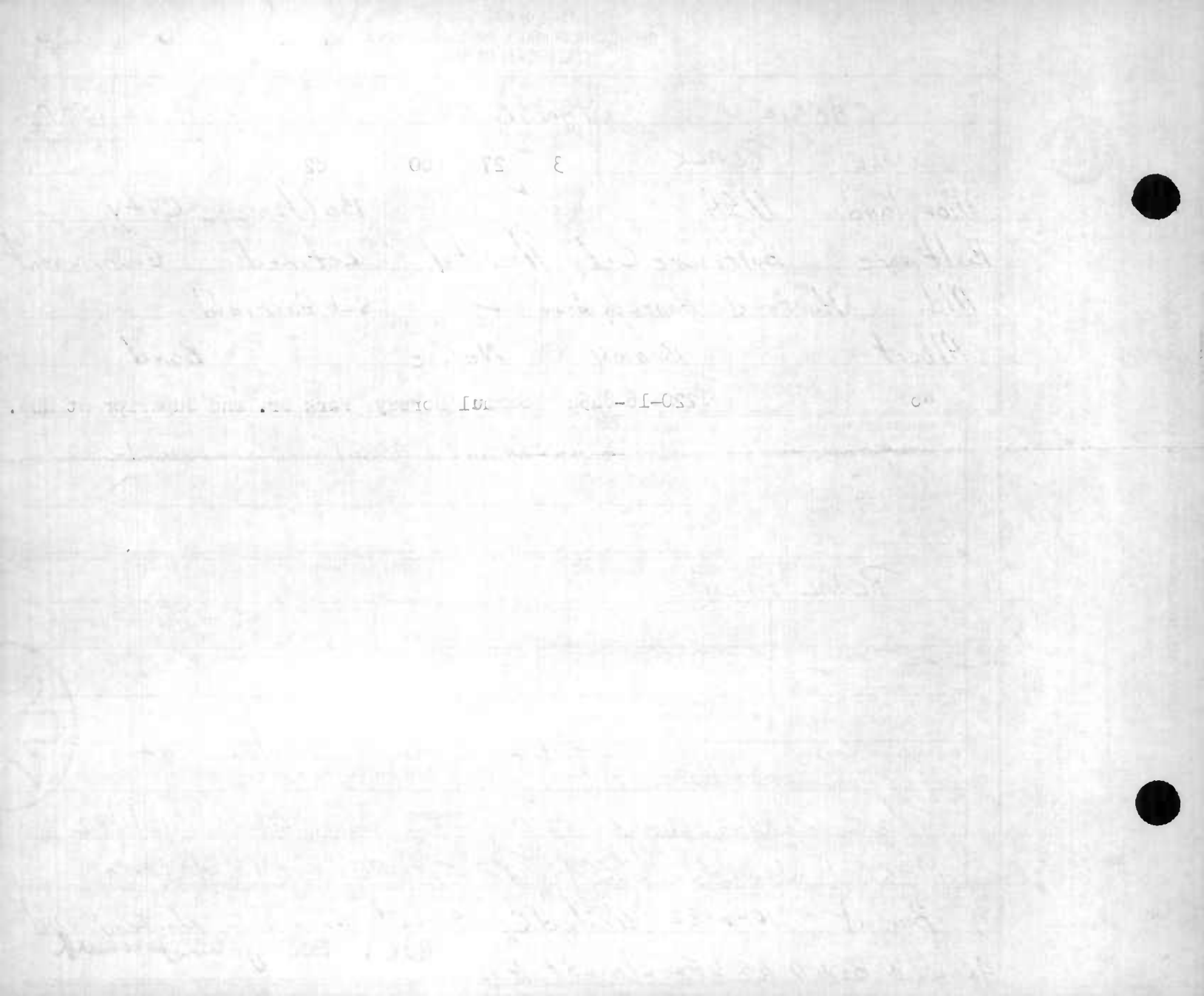
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARRIE STANSBURY			2a. DATE OF DEATH MONTH DAY YEAR 10 1 82		2b. HOUR 150 P.M.
3. SEX FEMALE	4. RACE BLACK	5. DATE OF BIRTH MONTH DAY YEAR 3 27 00		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY Government
13a. USUAL RESIDENCE (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) Md.			13b. COUNTY Harford	13c. CITY OR TOWN Harford	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Albert Brown			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nellie Bond		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 220-18-8454		17. INFORMANT Samuel Dorsey	
				ADDRESS Park Dr. and Superior St. HDG.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4275 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH IMMEDIATE
DUE TO, OR AS A CONSEQUENCE OF (b) _____		
DUE TO, OR AS A CONSEQUENCE OF (c) _____		

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):
RENAL FAILURE

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/1/82 , 19 82 , to 10/1/82 , 19 82 , that (I) (we) last saw the deceased alive on 10/1/82 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Mart Schlusberg		DEGREE M.O.	22c. DATE SIGNED 10/1/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARTIN SCHLUSSELBERG		22e. ADDRESS BALTIMORE CITY HOSPITAL	

23a. BURIAL, CREMATION, REMOVAL (CHECK) Burial	23b. DATE 10-6-82	23c. NAME OF CEMETERY OR CREMATORY United Cem Sw Crd	23d. LOCATION CITY OR TOWN COUNTY STATE Aberdeen Harford Md
24. FUNERAL DIRECTOR NAME ADDRESS ARNOLD W. BEARD 353 Fountain St HDG.		25. DATE REC'D. BY REGISTRAR NOV 1 1982	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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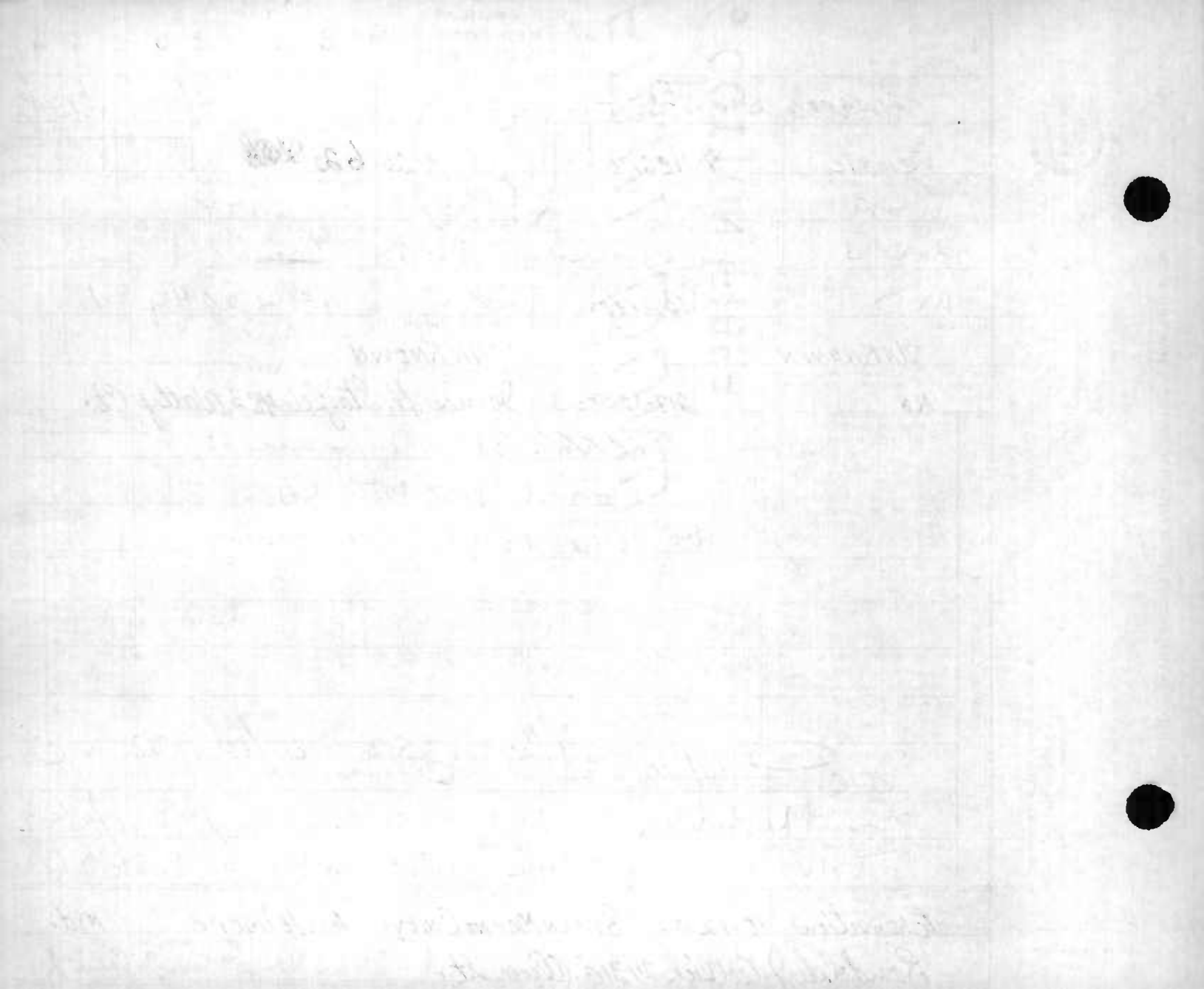
STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 82 26237	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) Edward STAPPLER						2a. DATE OF DEATH MONTH DAY YEAR 10/5/82		2b. HOUR 10⁰⁵ AM			
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 10 15 93		6. AGE (IN YEARS, LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. PROPRIETOR (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. BUSINESS OR INDUSTRY STAPPLER FUR CO.			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE MD		13b. COUNTY BALT.		13c. CITY OR TOWN OWINGS MILLS		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2410 Velvet Valley Way			
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH SOLOMON STAPPLER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH CITROEN							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES				16b. SOCIAL SECURITY NO. 216 32 4264		17. INFORMANT LAURENCE STAPPLER 2410 VELVET VALLEY WAY OWINGS MILLS, MD 21117					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 5529 IMMEDIATE CAUSE (a) Cardiac pulmonary arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) Upper GI bleed, low flow state DUE TO, OR AS A CONSEQUENCE OF (c) Incarcerated small bowel APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION 9/21/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Incarcerated small bowel				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9/21 , 19 82 , to 10/5 , 19 82 , that (I) (we) last saw the deceased alive on 10/5 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE S. JASKUSCZY DEGREE						22c. DATE SIGNED 10/5/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. JASKUSCZY						22e. ADDRESS Sinai Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 7, 1982		23c. NAME OF CEMETERY OR CREMATORY OHEB SHALOM MEM. PARK		23d. LOCATION REISTERSTOWN COUNTY BALTO. STATE MD					
24. FUNERAL DIRECTOR SOL LEVINSON & BROS., INC. NAME ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR OCT 13 1982 25b. REGISTRAR'S SIGNATURE John J. Canine					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 6 2 3 8			
1- FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST STAYLEY ELLEN E. STAYLEY				2a. DATE OF DEATH MONTH DAY YEAR 10 / 10 / 82		2b. HOUR P M 1:45 P M	
3. SEX Female		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 1 12 1920		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS 62 8 11 YRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) USA		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.	
10. CITY OR TOWN OF DEATH Balto		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSP		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) none		12b. KIND OF BUSINESS OR INDUSTRY none	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE 13b COUNTY 13c CITY OR TOWN MD 13 210				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 483 Watty St.	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-22-5053		17. INFORMANT ADDRESS James H. Stayley 483 Watty Ct.			
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Probable Cache neck arrest 1509 DUE TO, OR AS A CONSEQUENCE OF (b) Probable Metastatic CA. DUE TO, OR AS A CONSEQUENCE OF (c) Prob. Carcinoma of esophagus							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/29 19 82, to 10/10 19 82, that (I) (we) last saw the deceased alive on 10/10 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE David Matchar				DEGREE MD		22c. DATE SIGNED 10/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID				22e. ADDRESS Lutheran Hosp, Balto 21216			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10-12-82		23c. NAME OF CEMETERY OR CREMATORY GREEN MOUNT Ctry.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Randolph J. Collick				ADDRESS 2431 E. Oliver St.		25a. DATE REC'D. BY REGISTRAR OCT 13 1982	
				25b. REGISTRAR'S SIGNATURE John J. Ganiel			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 5 2 2 6 2 3 9	
1. DECEASED NAME (TYPE OR PRINT)		FIRST 2		MIDDLE 1		LAST Steele		2a. DATE KNOWN OF DEATH		MONTH DAY YEAR HOUR	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS) LAST BIRTHDAY YRS.		7c. DATE PRONOUNCED DEAD		MONTH DAY YEAR HOUR	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Mississippi		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4100 Blk. E. Monument St.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS			
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT Latimer Funeral Home, Philadelphia Mi		ADDRESS					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8052 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:50XX 9 23 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Pedestrian struck by train							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) railroad tracks		21f. LOCATION STREET CITY OR TOWN COUNTY STATE N. of Monument St., Balto. Md.							
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Thomas D. Smith, M.D.		TITLE (SPECIFY) M.D. Deputy Chief						DATE SIGNED 9/23/82			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS 111 Penn St. Balto., MD.									
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE Oct 4, 82		23c. NAME OF CEMETERY OR CREMATORY Mt. Zion		23d. LOCATION CITY OR TOWN COUNTY STATE Philadelphia Mississippi					
24. FUNERAL DIRECTOR Latimer, 250 Corver Ave P.O. Box 578 Philadelphia Mississippi 191350						25a. DATE REC'D. BY REGISTRAR OCT 14 1982		25b. REGISTRAR'S SIGNATURE John J. Canfield			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 2 4 0			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
STEIN Mercedes LEE STEIN								10-17-82					10:15 A M
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (IN YEARS (LAST BIRTHDAY))		IF UNDER 1 YEAR		IF UNDER 24 HRS			
Female		W. HITE		9 11 21		Xxxx 61 YRS		MONTHS		DAYS		HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH							
North Carolina		XXXX USA				Baltimore City MD							
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		LEVINDALE				HOUSEWIFE		AT HOME					
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
		MARYLAND		BALTO.		TIMONIUM		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		302 VALDENE CT.		#21093	
14 FATHER'S NAME		15. MOTHER'S MAIDEN NAME											
FIRST MIDDLE LAST		FIRST MIDDLE LAST											
MOSES ROSENBERG		DOROTHY BANDEL											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT		HANS E. STEIN							
NO		216-14-3521		302 VALDENE CT.		TIMONIUM, MD 21093							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Metastatic Cancer of Breast</u> 1749 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?							
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE			
22a. I certify that he (this hospital) attended the deceased from <u>8/10/82</u> to <u>10/17/82</u> , that he (we) lost saw the deceased alive on <u>10/10/17/1982</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, he (we) did (did not) view the body after death.													
22b. SIGNATURE		DEGREE		22c. DATE SIGNED									
<u>Mary John</u>		MD		10/17/82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS											
KHIN - M. TUN.		2110 Pot Spring Road Md 21093.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE			
BURIAL		OCT. 18, 1982		BALTIMORE HEBREW		REISTERSTOWN		BALTO.		MD			
24 FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE									
SOL LEVINSON & BROS., INC.		OCT 20 1982		<u>J. C. C. C. C.</u>									
6010 REISTERSTOWN RD. BALTO., MD 21215													

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner may be notified and a post-mortem examination may be required.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 2 4 1

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <u>Lewis H. Steinhoff</u>			2a. DATE OF DEATH MONTH DAY YEAR <u>10/24/82</u>			2b. HOUR <u>8 45</u> P.M.	
3. SEX <u>MALE</u>		4. RACE <u>WHITE</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>9 7 1903</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>79</u> YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>OHIO</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>BALTO CITY</u> MD.	
10. CITY OR TOWN OF DEATH <u>BALTO</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>CITY HOSP.</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>STEEL WORKER</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>	
13a. STATE <u>MD</u>				13b. CITY OR TOWN <u>DUNDALK</u>		13c. STREET ADDRESS <u>8127 DUNDALK AVE.</u>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>LEWIS</u>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>ANNIE HEFT</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>				16b. SOCIAL SECURITY NO. <u>213-07-7657</u>		17. INFORMANT <u>LUCILLE STEINHOFF</u> ADDRESS <u>SAME</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY <u>1539 IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u></u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) <u>Metastases Colon Ca / Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/24/82</u> 19 <u>82</u> to <u>10/24/82</u> 19 <u>82</u> that (I) (we) lost saw the deceased alive on <u>10/24/82</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>John R. Whittemore</u> MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10/24/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u>		23b. DATE <u>10/27/82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>OAK LAWN</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTO MD.</u>	
24. FUNERAL DIRECTOR NAME <u>CONNELLY FUNERAL HOME OF DUNDALK</u>				25a. DATE REC'D. BY REGISTRAR <u>OCT 27 1982</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Connelly</u>	

GENERAL BUSINESS UNIT OF THE BANK
BANK OF AMERICA
DALLAS, TEXAS

TO THE BOARD OF DIRECTORS
FROM THE VICE PRESIDENT
DATE: 10/15/54
SUBJECT: [illegible]

1. [illegible]
2. [illegible]
3. [illegible]
4. [illegible]
5. [illegible]
6. [illegible]
7. [illegible]
8. [illegible]
9. [illegible]
10. [illegible]

11. [illegible]
12. [illegible]
13. [illegible]
14. [illegible]
15. [illegible]
16. [illegible]
17. [illegible]
18. [illegible]
19. [illegible]
20. [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, this should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be contacted for an autopsy.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 2 6 2 4 2	
1. DECEASED NAME (TYPE OR PRINT) CATHERINE STEVENS					2a. DATE OF DEATH MONTH DAY YEAR 10 26 82			2b. HOUR 525 A.M.			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 5 16 26		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SINAI HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSE WIFE		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5255 St. Charles Ave			
14. FATHER'S NAME FIRST MIDDLE LAST William Jenkins				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Smith							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 218-22-5102		17. INFORMANT ADDRESS Herman L. Burton 5255 St. Charles Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC BREAST CA 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DOE TO, OR AS A CONSEQUENCE OF (b) (R) & (L) pleural effusions (malignant) DOE TO, OR AS A CONSEQUENCE OF (c) Renal Failure									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Diabetes Mellitus											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from OCT 28 , 19 82 , to OCT 26 , 19 82 , that (1) we last saw the deceased alive on OCT 26 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) we (did) (did not) view the body after death.											
22b. SIGNATURE Jeffrey M. Mocc, M.D.			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/26/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) JEFFREY M. Mocc, M.D.			22e. ADDRESS								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/29/82		23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Cheltenham MD.				
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. north Ave.			ADDRESS			25a. DATE REC'D. BY REGISTRAR OCT 27 1982					
						25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>					

2822

1892



X

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It should be returned to the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 2 4 3 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>MARGARET J. STEVENS</u>						2a. DATE OF DEATH MONTH DAY YEAR <u>10/31/82</u>				2b. HOUR <u>4:55</u> <u>AM</u>			
3. SEX <u>Female</u>		4. RACE <u>White</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>7 24 1921</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>61</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS <u>0 0</u>		IF UNDER 24 HRS. HOURS MIN. <u>0 0</u>			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>New Jersey</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>City</u> MD.							
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>University of Maryland Hospital</u>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Homemaker</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>					
13a. STATE <u>Maryland</u>						13b. COUNTY <u>Harford</u>		13c. CITY OR TOWN <u>Aberdeen</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>William Alloway</u>						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Tillie Alloway</u>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u>						16b. SOCIAL SECURITY NO. <u>156-07-2155</u>		17. INFORMANT ADDRESS <u>Maryland 21001</u> <u>William S. Stevens, 309 Carter St., Aberdeen,</u>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardio-circulatory collapse</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Septic Shock</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Naso Pharyngeal Ca</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>9/80</u>			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>10-4</u> , 19 <u>82</u> , to <u>10-31</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>10-31</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>Howard S. Freedland MD</u>						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10/31/82</u>					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Howard Freedland MD</u>						22e. ADDRESS <u>22 S. Greene St Balto MD 21202</u>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal/Burial</u>				23b. DATE <u>3 Nov. 1982</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Puritan Mem. Gardens</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Peabody Essex Mass.</u>					
24. FUNERAL DIRECTOR NAME <u>Tarring Funeral Home, P.A., Aberdeen, Md. 21001-339</u>						25a. DATE REC'D. BY REGISTRAR <u>NOV 5 1982</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>					

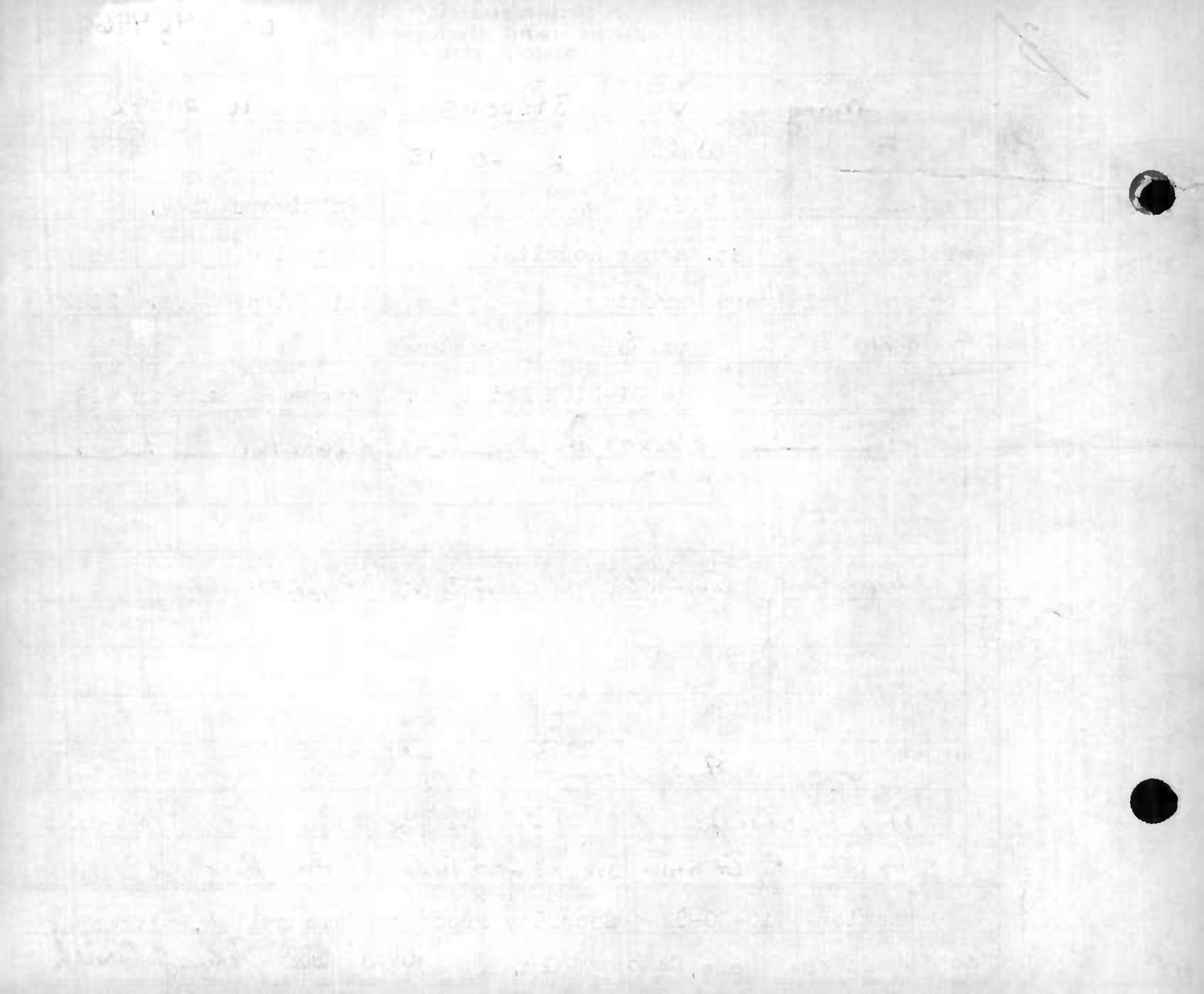
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 2 4 4	
1. STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		Mary Violet Stevens Mary V Stevens				2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		White		MONTH DAY YEAR 2 20 15		67 YRS		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH					
Maryland		U.S.A.				Baltimore City, MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
Baltimore		St. Agnes Hospital				Housewife		Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS			
Maryland				Baltimore		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		1112 Linden Ave. 21227			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST Charles Eversole				FIRST MIDDLE LAST Margaret Davis							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS			
No				N/A		214-01-2163		Philip A. Stevens Same as: #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute myocardial infarction										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours	
DUE TO, OR AS A CONSEQUENCE OF (b)											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Neuronal arthritis, pancreatitis, hypertension											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
								YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NO: WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) (this hospital) attended the deceased from 10/15, 19 80, to 10/24, 19 80, that (1) (we) lost the deceased on 10/24/80, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If I did not view the body after death, so state.)											
22b. SIGNATURE Charles R. Graham Jr.				DEGREE M.D.				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/28/80	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHARLES R. GRAHAM JR				22e. ADDRESS 299 Federal Rd Belt Rd Linc							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation				23b. DATE 10-30-82		23c. NAME OF CEMETERY OR CREMATORY Security Process		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Baltimore, MD			
24. FUNERAL DIRECTOR MacNabb Funeral Home, Catonsville, MD						25a. DATE REC'D. BY REGISTRAR NOV 3 1982		25b. REGISTRAR'S SIGNATURE John J. Carver			



DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 6 2 4 5

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		ESTIMATED		MONTH		DAY		YEAR		2b. HOUR	
Alonzo						Stevenson		10		24		1982						M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR	
male	black	5 9 14		68 YRS.						10		24		1982				8:20 a.m.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH											
New Jersey		USA		WIDOWED		DIVORCED		Baltimore City,										MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		206 N. Chester Street																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Md				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		206 N. chester Street											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. WAS DECEASED EVER IN U.S. ARMED FORCES?		17. INFORMANT		ADDRESS											
David		Eleanor		Yes		Violetta Weaver		206 N. Chester Street											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Hypertensive Cardiovascular Disease		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
4029				(b)															
				(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)															
		P.M. 19																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY		STATE									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .		22b. TITLE (SPECIFY)		Assistant		MEDICAL EXAMINER		DATE SIGNED		10-24-82							
ACTUAL SIGNATURE		Dennis F. Smyth, M.D.		ADDRESS		111 Penn Street													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE							
Burial		10/28/82		Md Veteran Cemetery		Crownsville						Md							
24. FUNERAL DIRECTOR		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE															
William C. March F/H 1101 E. North Avenue		OCT 26 1982		John J. Calver															

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 1 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

U.S.

RECEIVED BY THE DIRECTOR
OF THE BUREAU OF THE
CENSUS
WASHINGTON, D.C. 20540

DAVID W. K.
JAN 10 1960

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 only to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CARLTON W STEWART						2a. DATE OF DEATH MONTH DAY YEAR Oct. 29, 1982		2b. HOUR 5:55 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 24, 1908		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN IF UNDER 24 HRS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Andrews, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Welder* Westinghouse		12b. KIND OF BUSINESS OR INDUSTRY	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Md.		13b. COUNTY Balto.		13c. CITY OR TOWN Arbutus		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2007 Smith Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 1942-1945		17. INFORMANT ADDRESS 2007 Smith Ave. Balto. Md. 21227		Mrs. Georgeann M. Stewart			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Keep arrest. DUE TO, OR AS A CONSEQUENCE OF (b) COPD, pneumonia. DUE TO, OR AS A CONSEQUENCE OF (c) Septicemia. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: aortic aneurysmal operation.									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10/20/82 to 10/29/82 , that (I) (we) lost saw the deceased alive on 10/29/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Jonide				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10/29/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) PURUSHOTRAM M 1 TRA				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 1, 1982		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.			
24. FUNERAL DIRECTOR G. Truman Schwab 3512 Frederick Ave. Balto. Md.				25a. DATE REC'D. BY REGISTRAR NOV 5 1982		25b. REGISTRAR'S SIGNATURE John J. Connel			

Feb. 29, 1962

White, W. G. A. Baltimore, Md. X

Baltimore, Md. 321. James Road. "Welder" Westinghouse

Mr. White, Baltimore, Md. X 3007 Smith Ave.

1962-1962 21-07-0498 Mrs. Georgeanna M. Stewart 3007 Smith Ave. Baltimore, Md. 21227

RECEIVED



Nov. 1, 1962 3007 Smith Ave. Baltimore, Md. 21227

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and item 18 completed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 2 2 6 2 4 7 REG. NO.			
1. FOR STATE REGISTRAR					2a. DATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT) Clara Bell Stewart					MONTH 10 DAY 1 YEAR 82			
3. SEX female					7b. HOUR M			
4. RACE black					5. DATE OF BIRTH			
5. DATE OF BIRTH MONTH 27 DAY 07					6. AGE (IN YEARS LAST BIRTHDAY)			
7a. BIRTHPLACE (STATE OR FOREIGN) North Car.					75			
7b. CITIZEN OF WHAT COUNTRY? USA					IF UNDER 1 YEAR MONTHS DAYS			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.			
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore					MD.			
10. CITY OR TOWN OF DEATH Baltimore					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION			
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION 4300 Elderon Ave.					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
12b. KIND OF BUSINESS OR INDUSTRY								
13a. STATE Md.					13b. COUNTY			
13c. CITY OR TOWN Baltimore					13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
13e. STREET ADDRESS 4300 Elderon Ave.								
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No					16b. SOCIAL SECURITY NO.			
17. INFORMANT ADDRESS Lorenzo Stewart 4300 Elderon Ave.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Acute Myocardial Infarction					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
4100 DUE TO, OR AS A CONSEQUENCE OF (b) CARDIAC MYOPATHY								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)					21e. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 1992 to 1982, that (I) (we) last saw the deceased alive on SEP 20 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Richard M. Hunt MD					22c. DATE SIGNED 10-4-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RICHARD M. HUNT					22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial					23b. DATE 10/4/82			
23c. NAME OF CEMETERY OR CREMATORY KING MEMORIAL PK.					23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD.			
24. FUNERAL DIRECTOR NAME LEROY O. DYETT 4600 LIBERTY HGTS. AVE.					25a. DATE REC'D. BY REGISTRAR OCT 5 1982			
25b. REGISTRAR'S SIGNATURE John J. Connel								

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Burials may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be mailed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner will be notified or will

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				Born <u>Edmond Lewis Stewart</u> 2 6 2 4 8			
1 - STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>Edmond Stewart Stewart</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>10/08/82</u>			
2. SEX <u>MALE</u>				2b. HOUR <u>4:25</u> M.			
3. RACE <u>Black</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>08 11 68</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>14</u> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Havre de Grace Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.	
10. CITY OR TOWN OF DEATH <u>Baltimore.</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>University of Maryland Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Student.</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <u>Maryland</u>				13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
13c. COUNTY <u>HARFORD</u>		13d. CITY OR TOWN <u>ABERDEEN</u>		13e. STREET ADDRESS <u>601 Plaza Court,</u>			
14. FATHER'S NAME FIRST MIDDLE LAST <u>Edmond Stewart Jr.</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Cynthia Taylor.</u>		16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <u>NO</u>			
16b. SOCIAL SECURITY NO. <u>NONE.</u>		17. INFORMANT ADDRESS <u>FATHER. 601 Plaza Court, Aberdeen Md.</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>2040 IMMEDIATE CAUSE (a) Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Acute lymphocytic leukemia sepsis.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Acute lymphocytic leukemia</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>September 28</u> , 19 <u>82</u> , to <u>October 8</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>October 8</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Virginia A. Keane</u>				DEGREE		22c. DATE SIGNED <u>10/8/82.</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Virginia A Keane</u>				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			
22e. ADDRESS <u>University of Maryland Hospital</u>							
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) <u>Burial</u>		23b. DATE <u>10-11-82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Union United</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Aberdeen Harford Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Arnold W. Beard</u>				25a. DATE REC'D. BY REGISTRAR <u>OCT 18 1982</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

FOR
1. STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 2 4 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) STOKES, Beatrice E.			2a. DATE OF DEATH MONTH DAY YEAR 10 1 82			2b. HOUR 1 PM			
3. SEX F.		4. RACE NEGRO		5. DATE OF BIRTH MONTH DAY YEAR 7 13 22		6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? US of A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) J. L. Deaton Medical Center				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY WELDER	
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21216 962 FRANKLINTOWN ROAD	
14. FATHER'S NAME FIRST MIDDLE LAST WALTER STOKES				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY HARRISON					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 220 01 4464		17. INFORMANT ADDRESS MR. ARTHUR STOKES 962 FRANKLINTOWN ROAD					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Failure 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Metastatic Duct Cell Carcinoma of Lung DUE TO, OR AS A CONSEQUENCE OF (c) Bone Metastasis								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9/30 , 19 82 , to 10/1 , 19 82 , that (I) (we) last saw the deceased alive on 10/1 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Katherine M. Sanzaro, MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10/1/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. SANZARO				22e. ADDRESS J. L. Deaton Medical Center					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/5/82		23c. NAME OF CEMETERY OR CREMATORY ARBUTUS MEM. PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE (BALTO.) MD.			
24. FUNERAL DIRECTOR NAME LEWIS T. GWYNN 4517 PARK HEIGHTS AVENUE				25a. DATE REC'D. BY REGISTRAR OCT 4 - 1982		25b. REGISTRAR'S SIGNATURE Joan J. Connel			

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908 PRAIRIEVIEW RD

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BALTIMORE

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HARTMAN

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220 of 1104 MR. ARTHUR STOKES 908 PRAIRIEVIEW RD

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(BARTO), MD.

RETIRED

RETIRED MR. FANN

10/2/55

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10/2/55 10/2/55 10/2/55

TO HOSPITAL C. - ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 6 2 5 0 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) MOSES N STOKES				2a. DATE OF DEATH MONTH DAY YEAR 10 11 82				2b. HOUR MIN. 6:30 P.M.
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 11 14 13		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MD. HOSP			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.				13b. COUNTY		13c. CITY OR TOWN BALTIMORE		
13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				13e. STREET ADDRESS 910 Preach Street				
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie Jackson				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 413-09-1971		17. INFORMANT ADDRESS Edna Stokes 3410 St Ambrose St				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1991 IMMEDIATE CAUSE (a) CARDIO RESPIRATORY ARREST. DUE TO, OR AS A CONSEQUENCE OF (b) CARCINOMA (MT '10) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 110.								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from SEPT 8 , 19 82 , to OCT 11 , 19 82 , that (I) (we) lost saw the deceased alive on OCT 11 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE B. A. Crahan, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/11/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ATTAR, SAF UH.				22e. ADDRESS				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/15/82		23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville Md		
24. FUNERAL DIRECTOR NAME ADDRESS Wm. c. March F/H 1101 e. North ave				25a. DATE REC'D. BY REGISTRAR OCT 14 1982				
				25b. REGISTRAR'S SIGNATURE John J. Givish				

Original certificate filed 10/26/82 at 1:59 PM, Baltimore, Md. 21011
DIVISION OF VITAL RECORDS, 201 W. Preston St., Baltimore, Md. 21201
Film G574 12/14/82 re

DUPLICATE

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				82-26251 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JANET G. STONE				2a. DATE OF DEATH MONTH DAY YEAR 9 18 82			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 16 36		6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3306 Beech Ave.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Waitress		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md.				13b. COUNTY		13c. CITY OR TOWN Balto.	
14. FATHER'S NAME FIRST MIDDLE LAST Rex Tackett				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maxine Whitt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 213-32-3329		17. INFORMANT ADDRESS Philip Blair 10757 Cortage Walk Columbia, Md. 21044	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Hepatocellular carcinoma 1552 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one year							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 12/19/81 to 9/18/82 , that (I) (we) last saw the deceased alive on 9/17/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Marshall A. Levine MD				22c. DATE SIGNED 10/10/82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) Marshall A. Levine	
22e. ADDRESS 711 W. 40th St., Balto., Md.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 9/19/82		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board				25a. DATE REC'D. BY REGISTRAR DEC 14 1982		25b. REGISTRAR'S SIGNATURE John J. Connelley	

88-45-221

THE UNITED STATES DEPARTMENT OF JUSTICE
WASHINGTON, D. C. 20535

RECEIVED

U.S. DEPARTMENT OF JUSTICE
OFFICE OF THE ATTORNEY GENERAL
WASHINGTON, D. C. 20535

DEC 14 1988

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		XX MONTH DAY YEAR		2b. HOUR			
HELEN		N.		STONESIFER				10-17-82		10-17-82		M			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD			
Fe		White		4/12/1912		70 YRS.		MONTHS		DAYS		10-17-82, 5:55A			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		X NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH							
Penna.		USA		WIDOWED		DIVORCED		Baltimore City				MD			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore		Baltimore City Hospital		Housewife		Own Home									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS							
Penna.		Lancaster		Elizabethtown		YES X NO		305 Mount Joy St.							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
Simon		Katie H. Barto													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS		17022							
No		160-14-2275		Carl R. Stonesifer,		Elizabethtown, Pa.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9588 IMMEDIATE CAUSE (a) Thermal injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?					
										YES X NO					
21a. EXTERNAL CAUSE WAS UNDERLYING X OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY A.M. MONTH DAY YEAR 12:05 10-16-82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) self/immolation											
21d. INJURY OCCURRED WHILE AT WORK NOT WHILE AT WORK X		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 305 S. Mount Joy St. Elizabethtown, Pennsylvania											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes Accident Suicide X Homicide Undetermined manner TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10-18-82 EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D. ADDRESS 111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (CITY OR TOWN)		23e. DATE REC'D. BY REGISTRAR		23f. REGISTRAR'S SIGNATURE					
Burial		10/20/82		Stauffer's Mennonite		Conewago Twp., Dauphin, Penna.		OCT 25 1982		John J. [Signature]					
24. FUNERAL DIRECTOR (NAME) Kenneth W. Presburn ADDRESS Stewartstown, Penna.															

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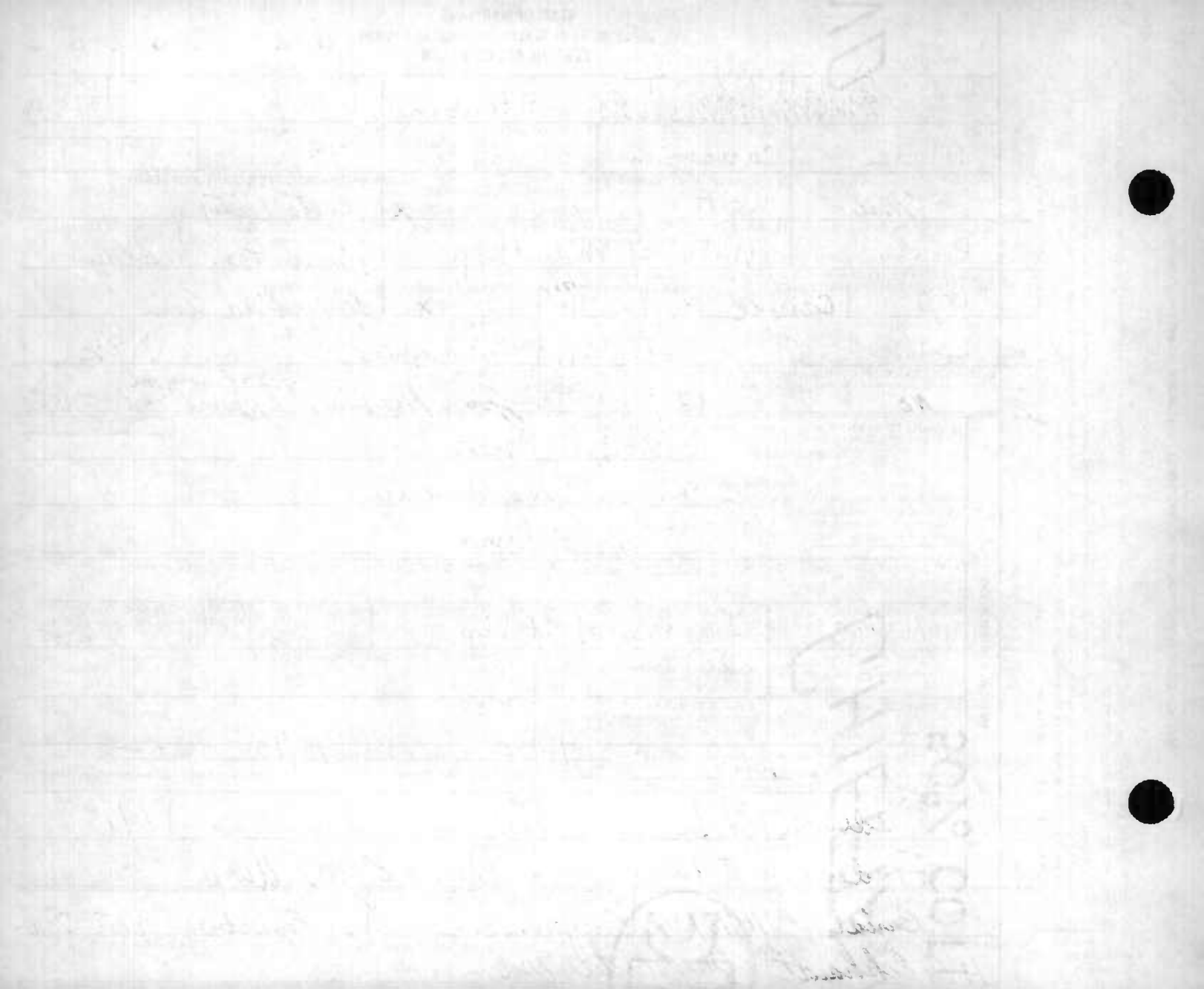
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 6 2 5 3			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>ANTHONY STRUBIN</u>				2a. DATE OF DEATH MONTH DAY YEAR 10/15/82			
3. SEX <u>Male</u>				2b. HOUR 7:10 P.M.			
4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH DAY YEAR 01 04 04		6. AGE (IN YEARS LAST BIRTHDAY) 78		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.	
10. CITY OR TOWN OF DEATH <u>Balt.</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Univ of Md Hosp</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Carpenter</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Bldg.</u>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE <u>MD</u> COUNTY <u>Carroll</u> CITY OR TOWN <u>Synoville</u>				13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13c. STREET ADDRESS <u>Springfield Ave</u>	
14. FATHER'S NAME FIRST <u>John</u> MIDDLE <u>B</u> LAST <u>Strubin</u>		15. MOTHER'S MAIDEN NAME FIRST <u>Josephine</u> MIDDLE <u>V</u> LAST <u>Vitek</u>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u>			
16b. SOCIAL SECURITY NO. <u>218-09-7182</u>		17. INFORMANT <u>Joan Hopkins</u>		ADDRESS <u>5523 Emory Rd</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <u>1629</u> IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic lung disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cancer of lung</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION <u>10/13/82</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>fracture of Rt hip</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/11/82</u> , 19 <u>82</u> , to <u>10/15</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>10/15</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Frederick T Lohr</u>		DEGREE <u>M.D.</u>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10/15</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Frederick T Lohr</u>		22e. ADDRESS <u>Univ of Md Hosp</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>10/18/82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Evergreen Mem. Park</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Baltimore Md.</u>	
24. FUNERAL DIRECTOR <u>H. J. Eckhardt</u>		DATE REC'D. BY REGISTRAR <u>10/19/82</u>		25. REGISTRAR'S SIGNATURE <u>[Signature]</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 2 5 4					
1. FOR STATE REGISTRAR										REG. NO.					
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
JOSEPH					STUCHINSKAS Stuchinsky					10 2 82				5:10 AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.					
Male		White		5 MONTH 17 DAY 03 YEAR		79 YRS.		MONTHS DAYS		HOURS MIN					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
Pennsylvania		U.S.A.				Baltimore City MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY									
Baltimore		St. Agnes Hosp		Tool Repair		G&L Comp.									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS							
Maryland		Baltimore		English Counsel				3721 Century Avenue		21227					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME													
John		Stuchinsky		Marcella		KdTokas									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS									
NO		212-09-8872		Mary L. Stuchinskas		3721 Century Ave.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1579 IMMEDIATE CAUSE (a) <u>Pancreatic Carcinoma.</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)															
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that (I) (this hospital) attended the deceased from <u>8-5-1982</u> , to <u>10-2-1982</u> , that (I) (we) last saw the deceased alive on <u>10-2-1982</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE				DEGREE				22c. DATE SIGNED							
Kaushaleन्द्र K. Singh.				MD.				10-2-82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS											
KAUSHALENDRA K. SINGH.				ST. AGNES HOSPITAL. 900 CATON AV. BALTIMORE.											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE									
Burial		10/5/82		Glen Haven Cemetery		Glen Burnie A.A. Maryland									
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE							
Hubbard Funeral Home, Inc.				OCT 4 - 1982				John J. Conner							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. The law may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 2 5 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PATRICK D. STURGILL			2a. DATE OF DEATH MONTH DAY YEAR 10 27 82			2b. HOUR 5 ⁰⁰ P.M.				
3. SEX Male		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR 9 2 88		6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ky.		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer Self		12b. KIND OF BUSINESS OR INDUSTRY Employed		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 6220 Ridgeview Ave. 21206			
14. FATHER'S NAME FIRST MIDDLE LAST Silas Sturgill			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Boggs			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no			16b. SOCIAL SECURITY NO. 231-12-7922	
17. INFORMANT ADDRESS 6220			17. INFORMANT Voyne J. Sturgill Ridgeview Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bacterial sepsis</u> <u>5742</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Biliary tract obstruction</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>Gallstone</u> DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u> <u>6 days</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Pneumonia, old age</u>										
19a. DATE OF OPERATION —			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from <u>10/21</u> , 19 <u>82</u> , to <u>10/27</u> , 19 <u>82</u> , that (1) <u>two</u> lost saw the deceased alive on <u>10/27</u> , 19 <u>82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (1) <u>we</u> had <u>no</u> view the body after death.										
22b. SIGNATURE <u>C Diana</u>			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 10/27/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles Diana			22e. ADDRESS Union Memorial Hospital							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-31-82		23c. NAME OF CEMETERY OR CREMATORY Flat Gap Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Wise County, Va.			
24. FUNERAL DIRECTOR NAME John C. Miller Inc. 6415 Belair Rd.			ADDRESS			25a. DATE REC'D. BY REGISTRAR NOV 1 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Lavelle</u>		



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 2 5 6

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ELLA K Styles			2a. DATE OF DEATH MONTH DAY YEAR 10-3-82		2b. HOUR 6:05 PM		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 3-24-1898		6. AGE (IN YEARS LAST BIRTHDAY) 84	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Garment Worker		12b. KIND OF BUSINESS OR INDUSTRY Factory	
13a. STATE MD		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST George ----- Krass		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna ----- Raphael		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-07-7040	
17. INFORMANT ADDRESS Mr. James H. Styles, 774 Powhatan Beach Rd.		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiopulmonary arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) diabetes		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Oct 3, 1982 to Oct 3, 1982 , that (I) (we) lost saw the deceased alive on Oct 3, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE E Dimond		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/3/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dimond		22e. ADDRESS University of Maryland Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 7, 1982		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME McCully Funeral Home, 130 E. Fort Ave. Balto. Md.		25a. DATE REC'D. BY REGISTRAR OCT 8 1982		25b. REGISTRAR'S SIGNATURE John J. Smith			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of age.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 2 6 2 5 1 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST FRANCIS E. SULLIVAN		2a. DATE OF DEATH MONTH DAY YEAR 10-10-82	
3. SEX Male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR 12-09-11	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Wash. D.C.		7b. CITIZEN OF WHAT COUNTRY? USA		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS	
10. CITY OR TOWN OF DEATH BALTO CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital		9. BALTIMORE CITY OR COUNTY OF DEATH CITY, BALTO. MD.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE STREET ADDRESS) Ind.		13b. COUNTY Baltimore		13c. STREET ADDRESS 1447 Washington Blvd. 21230	
14. FATHER'S NAME FIRST MIDDLE LAST Edward Sullivan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Marie Conway		12. USUAL OCCUPATION Electrician	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 526-28-3116		17. INFORMANT ADDRESS Mary M. Sullivan 1447 Washington Blvd. 21230	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) CARDIO PULMONARY ARREST DUE TO, OR AS A CONSEQUENCE OF (b) Squamous cell carcinoma of lung DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 minutes 3 months			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hyper calcemia					
19a. DATE OF OPERATION 9-8-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Lung Carcinoma		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 8-24 19 82 to 10-10 19 82, that (I) (we) lost saw the deceased alive on 10-10 19 82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Constance J. Meyd MD		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-10-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Constance J. Meyd MD		22e. ADDRESS Mercy Hospital Balto Md			
23a. BURIAL, CREMATION, REMOVAL Burial		23b. DATE 10-14-1982		23c. NAME OF CEMETERY OR CREMATORY Mt. Olivet Cemetery	
23d. LOCATION Baltimore 21223		23e. DATE REC'D. BY REGISTRAR OCT 14 1982		23f. REGISTRAR'S SIGNATURE John J. Connelley	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 above any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 2 2 6 2 5 8 REG. NO.			
1. FOR STATE REGISTRAR								
1. DECEASED NAME (TYPE OR PRINT) CHARLES A. SURWILLO					2a. DATE OF DEATH MONTH DAY YEAR 10 - 5 - 82			2b. HOUR 3:58 PM
3. SEX MALE		4. RACE CAUCASIAN		5. DATE OF BIRTH MONTH DAY YEAR 7 - 15 - 23		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTO, MD.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck-Driver		12b. KIND OF BUSINESS OR INDUSTRY Trucking Co.
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY - - -		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 215 S. VINCENT ST.
14. FATHER'S NAME FIRST MIDDLE LAST ANTHONY - SURWILLO					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST AGNES - YOURAWSKI			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) W.W. II		17. INFORMANT ADDRESS June Surwilo 215 S. Vincent St. (21223)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: 4960 IMMEDIATE CAUSE (a) Respiratory Insufficiency DUE TO, OR AS A CONSEQUENCE OF (b) Severe COPD & Cor Pulmonale DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Staph. aureus Endocarditis								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE D. Shamsuddin				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. SHAMSUDDIN				22e. ADDRESS BON SECOURS HOSPITAL				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 8, 1982		23c. NAME OF CEMETERY OR CREMATORY Crownsville Veterans		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville, Anne Arundel, Md.		
24. FUNERAL DIRECTOR NAME Lilly & Zeiler Inc. 1901 Eastern Ave. (21231)				25a. DATE REC'D. BY REGISTRAR OCT 6 1982		25b. REGISTRAR'S SIGNATURE [Signature]		

Illly & Miller Inc. 1001 Western Ave. (2121)

Butler Oct. 8, 1922 Greenville, Tennant: Greenwell, Mrs. Anne Arnold, Wb.

Yes . . . II

James Greenwell 212 S. Vincent St. (1122)

Tracy-Dillon Trading Co.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 2 5 9

REG. NO.

1- FOR
STATE
REGISTRAR

1 DECEASED NAME (TYPE OR PRINT) William Albert SUTER, Sr.			2a. DATE OF DEATH MONTH DAY YEAR October 13, 1982			2b. HOUR 11:02^A			
3 SEX Male		4 RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 18 1906		6 AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Md. Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Assembler		12b. KIND OF BUSINESS OR INDUSTRY Aircraft Mfg.	
13a. STATE Maryland			13b. COUNTY ---		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1919 McHenry St. 21223		
14 FATHER'S NAME FIRST MIDDLE LAST Samuel Lester Suter					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Elizabeth Barger				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 214-18-9678		17 INFORMANT ADDRESS 21206 Avis H French/5525 Daywalt Ave/Balto Md				
18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c) PART 1. DEATH WAS CAUSED BY 4292 IMMEDIATE CAUSE (a) cardiopulmonary arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH immediate YAS									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (1) this hospital attended the deceased from 10/13/82 , 19 82 , to same , 19 82 , that (1) (we) last saw the deceased alive on 10/13 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Bruce A. B. [Signature]					DEGREE ATTENDING PHYSICIAN MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/14/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. Brummerman MD					22e. ADDRESS 700 Washington Blvd BALTO				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/15/82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co., Maryland		
24. FUNERAL DIRECTOR NAME Walters Funeral Home/Pratt & Stricker Streets					25a. DATE REC'D. BY REGISTRAR OCT 14 1982		25b. REGISTRAR'S SIGNATURE John J. Conner		

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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BP

DHMH - 16 50M 4/82
(VRA 15, 4)

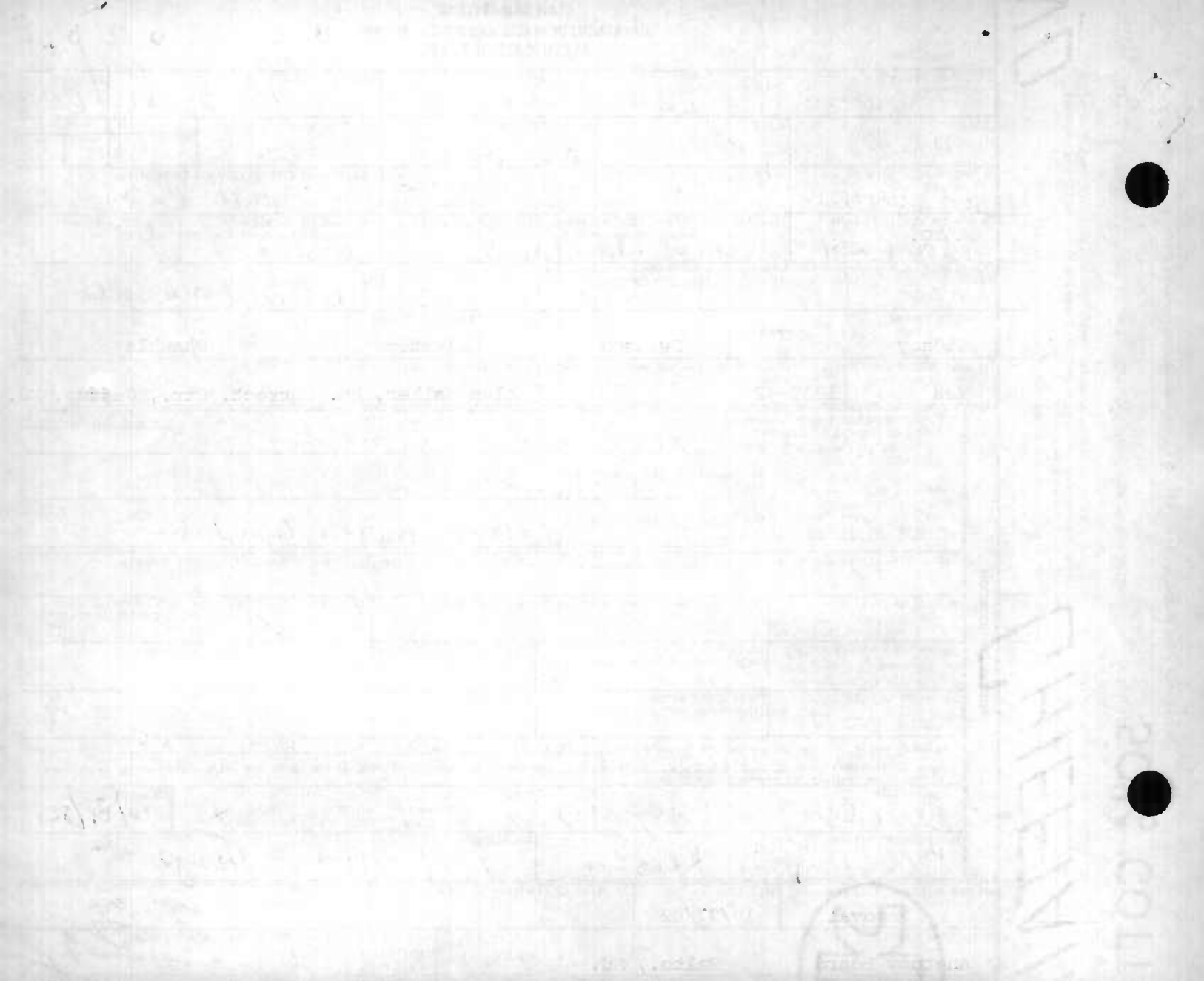
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 6 2 6.0 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) LOUIS SWANSON PMI				2a. DATE OF DEATH MONTH DAY YEAR 10 28 82			
3. SEX Male				2b. HOUR 6:50 AM			
4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 02 19 19		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO CITY MD.	
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) U. of Maryland		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) prisoner		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD		13b. COUNTY HTA		13c. CITY OR TOWN Jessup		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Sidney Swanson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Celester Shankle		16. SOCIAL SECURITY NO. 1939-42			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes		17. INFORMANT Helen Walker, Md. Correct. Ctr., Jessup, Md.		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 2028 IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) uremia DUE TO, OR AS A CONSEQUENCE OF (c) poorly differentiated lymphoma							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/19 19 82 , to 10/25 19 82 , that (I) (we) last saw the deceased alive on 10/22 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Beverly J. Kelsey MD				DEGREE MD		22c. DATE SIGNED 10/25/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Beverly J. Kelsey				22e. ADDRESS U. of Md. Hosp			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10/27/82		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board				25a. DATE REC'D. BY REGISTRAR NOV 4 1982			
ADDRESS Balto., Md.				REGISTRAR'S SIGNATURE John J. [Signature]			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 2 6 1

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Leona M. SWIEC			2a. DATE OF DEATH MONTH DAY YEAR October 28, 1982			2b. HOUR 11:17P_M			
3. SEX F		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 12 2 1907		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7. BIRTHPLACE (COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 609 E. 29TH ST.			
14. FATHER'S NAME FIRST MIDDLE LAST CLARENCE MICHEAU				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BERTHA CHEELSMAN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-10-8313		17. INFORMANT ADDRESS ANDREW SWIEC 609 E. 29TH ST. 2148					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary Arrest 4275 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a. Seizure Disorder									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from September 13, 1982 , to October 28, 1982 , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on October 28, 1982 , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.									
22b. SIGNATURE Ka Trent MD. DEGREE						22c. DATE SIGNED 10/29/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Karen Trent, M.D.						22e. ADDRESS c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL		23b. DATE 11-2-82		23c. NAME OF CEMETERY OR CREMATORY GARDENS OF FAITH		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD			
24. FUNERAL DIRECTOR HOFFMANN-SKARDA FH.						25a. DATE REC'D. BY REGISTRAR NOV 1 1982		25b. REGISTRAR'S SIGNATURE John G. Smith	

BP 2
DMMH - 16 50M 4/82
(VRA 15, 4)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

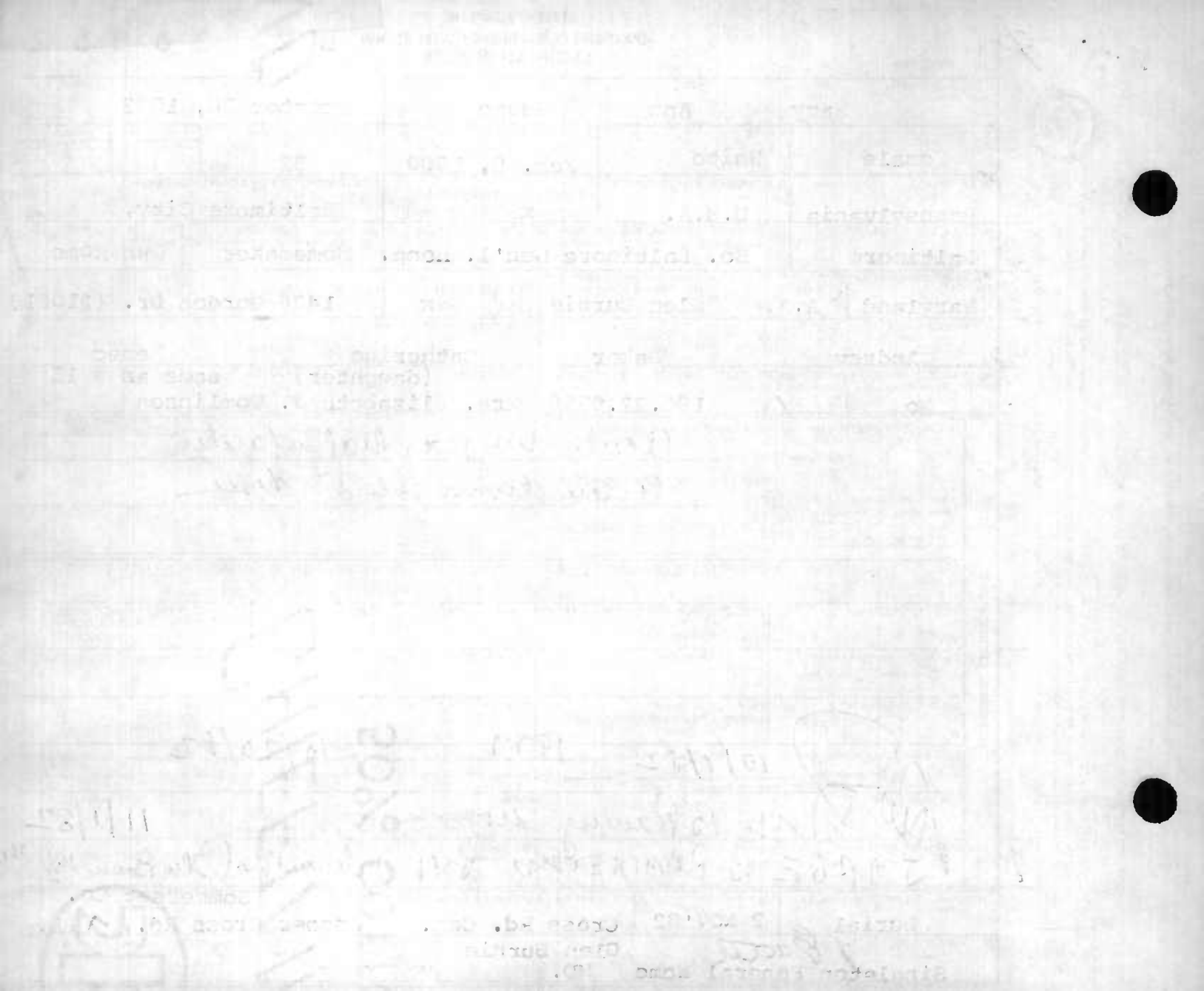
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 82 26262	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary Ann Swope						2a. DATE OF DEATH MONTH DAY YEAR October 30, 1982			2b. HOUR M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Feb. 9, 1900		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Baltimore Gen'l. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. STATE Maryland						13b. COUNTY A.A.		13c. CITY OR TOWN Glen Burnie		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Andrew Baker						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Nemec					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT (daughter) ADDRESS same as # 13 Mrs. Elizabeth J. Tomlinson							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (b) Certain chronic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK OR NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 1977, 19, to 10/30/82, that (I) (we) last saw the deceased alive on 10/17/82, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If deceased was not viewed, so state.)											
22b. SIGNATURE Jorge B Ramirez MD						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 11/1/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jorge B Ramirez MD						22e. ADDRESS 7845 Valwood Rd Glen Burnie MD 21061					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 2 NOV '82		23c. NAME OF CEMETERY OR CREMATORY Cross Rd. Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Jenner Cross Rd., PA.					
24. FUNERAL DIRECTOR NAME J. Easter		ADDRESS Glen Burnie MD.		25a. DATE REC'D. BY REGISTRAR NOV 3. 1982		25b. REGISTRAR'S SIGNATURE John J. Lohr					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

82 26263

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
Frances C Szczepanski						10 9 82				7 ²⁵ AM	
3. SEX		4. RACE		5. DATE OF BIRTH			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR	
Female		White		MONTH DAY YEAR # 07 08			79 YRS.			IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.					Baltimore City			MD.	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore			Mercy Hospital, Inc			Housewife					
13a. STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Md.					Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		519 S. Decker Avenue 21224		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME								
FIRST MIDDLE LAST Felix Stacharewski			FIRST MIDDLE LAST Josephine Zarzynski								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.			17. INFORMANT			ADDRESS		
No			214-03-2539			Frank Szczepanski			522 S. Decker Ave, Baltimore Md.		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) <u>Cardiac arrest</u>			
DUE TO, OR AS A CONSEQUENCE OF (b) <u>acute lateral myocardial infarction</u>			
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Sepsis</u>			
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that (I) (this hospital) attended the deceased from 10/4, 1982, to 10/4, 1982, that (I) (we) last saw the deceased alive on 10/4, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) sign this code after death.

22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
<u>Dorian Stacharewski</u>				10/4/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
Dorian S Stacharewski		Mercy Hospital			

23a. BURIAL, CREMATION, REMOVAL (TYPE)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
Burial		10-7-82		St. Stanislaus Cem.		Baltimore Baltimore Md.	
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Nicholas T. Matthews, 3021 Eastern Ave. Baltimore Md.		OCT 7 1982		<u>John J. [Signature]</u>			

82-20303

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 2 6 4 REG. NO.			
1. FOR STATE REGISTRAR													
1. DECEASED NAME (TYPE OR PRINT) DAVID TAKSAR					2a. DATE OF DEATH MONTH DAY YEAR FRI. OCT. 8, 1982					2b. HOUR 7:30AM			
3 SEX MALE		4 RACE WHITE		5 DATE OF BIRTH MAR. 15, 1894		6 AGE (IN YEARS LAST BIRTHDAY) 88 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3624 FORDS LANE APT. C (21215)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MERCHANT		12b. KIND OF BUSINESS OR INDUSTRY RETAIL			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3624 FORDS LANE APT. C (21215)				
14 FATHER'S NAME FIRST MIDDLE LAST SHALOM JOSEPH TAKSAR					15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HANNAH OPPEL								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 216-36-3200		17 INFORMANT ADDRESS (21215) MRS. CELIA TAKSAR 3624 FORDS LANE APT. C								
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary, metastatic,</u> <u>1991</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>organ undetermined</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>6 hrs</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: <u>ASCVD - Heart block + premature COPD</u>													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>10/8/82</u> 19 <u>82</u> , to <u>10/8/82</u> 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>10/8/82</u> 19 <u>82</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <u>H. Ronald Friedman</u> DEGREE						ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 10/8/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. RONALD FRIEDMAN						22e. ADDRESS 6715 PARK HEIGHTS AVE. (21215)							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/11/82		23c. NAME OF CEMETERY OR CREMATORY ARLINGTON CEMETERY			23d. LOCATION BALTIMORE, MD. COUNTY STATE					
24 FUNERAL DIRECTOR NAME SOL LEVINSON & BROS. ADDRESS 6010 REISTERSTOWN RD. BALTIMORE, MD. (21215)						25a. DATED BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 13 1982 <u>John J. Carver</u>							

1971-1972

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1969-1970

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 6 2 6 5 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) William Edward Tate				2a. DATE OF DEATH MONTH DAY YEAR 10/25/82		2b. HOUR 5 M	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 9 8 20		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1118 Whatcoat Street		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1118 Whatcoat St. 21217		14. FATHER'S NAME FIRST MIDDLE LAST Harry Tate		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Grant			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-18-3872		17. INFORMANT ADDRESS Mary Tate 1100 Pa. Ave. Apt. 306		17. INFORMANT ADDRESS Zion Towers	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 MYOCARDIAL INFARCTION DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 7/7/81 , 19____, to 10/18/82 , 19____, that (I) (we) last saw the deceased alive on 10/18/82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we did not view the body after death.)							
22b. SIGNATURE HOLLIS SEYNARKE, MD		DEGREE		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/26/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) HOLLIS SEYNARKE, MD		22e. ADDRESS 5010 YORK ROAD, BALTIMORE, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/28/82		23c. NAME OF CEMETERY OR CREMATORY Arbutus Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Avenue				25a. DATE REC'D. BY REGISTRAR OCT 29 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26266			
1. DECEASED NAME (TYPE OR PRINT)			FIRST Albert MIDDLE E. LAST Taylor			2a. DATE OF DEATH			KNOWN ESTIMATED <input checked="" type="checkbox"/> MONTH 10 DAY 29 YEAR 1982		2b. HOUR AM 7:54P		
3. SEX M		4. RACE White		5. DATE OF BIRTH MONTH 10 DAY 14 YEAR 1914		6. AGE (IN YEARS) 68 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD 10 29 1982		2d. HOUR 7:54P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
11. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital			17a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Truck Driver			17b. KIND OF BUSINESS OR INDUSTRY Bakery				
13a. STATE E			13b. COUNTY			13c. CITY OR TOWN Balt.			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 906 W. Lombard St. 21223	
14. FATHER'S NAME FIRST Albert MIDDLE MIDDLE LAST Taylor			15. MOTHER'S MAIDEN NAME FIRST Goldie MIDDLE MIDDLE LAST Phillips			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (O, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. Dr. M. II 28-01-5663			17. INFORMANT Address Katherine Taylor 906 W. Lombard St. 21223	
CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Salicylate intoxication</u> 9504 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 10/29/1982			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Ingested drug							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) Unknown			21f. LOCATION Lived: STREET 906 W. Lombard St. CITY OR TOWN Baltimore COUNTY Md. STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE <u>H. Guard</u>			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 10/29/82				
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.			ADDRESS 111 Penn Street, Baltimore, MD 21201										
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11-2-1982			23c. NAME OF CEMETERY OR CREMATORY Holly Hill Mem. Pk.			23d. LOCATION (CITY OR TOWN) White Marsh, Balt. Co. Md. STATE				
24. FUNERAL DIRECTOR (NAME) J. E. Egan, Son Inc.			ADDRESS 901 N. Charles St.			25a. DATE REC'D. BY REGISTRAR NOV 3 1982			25b. REGISTRAR'S SIGNATURE John J. Carroll				



NEW YORK

RECEIVED

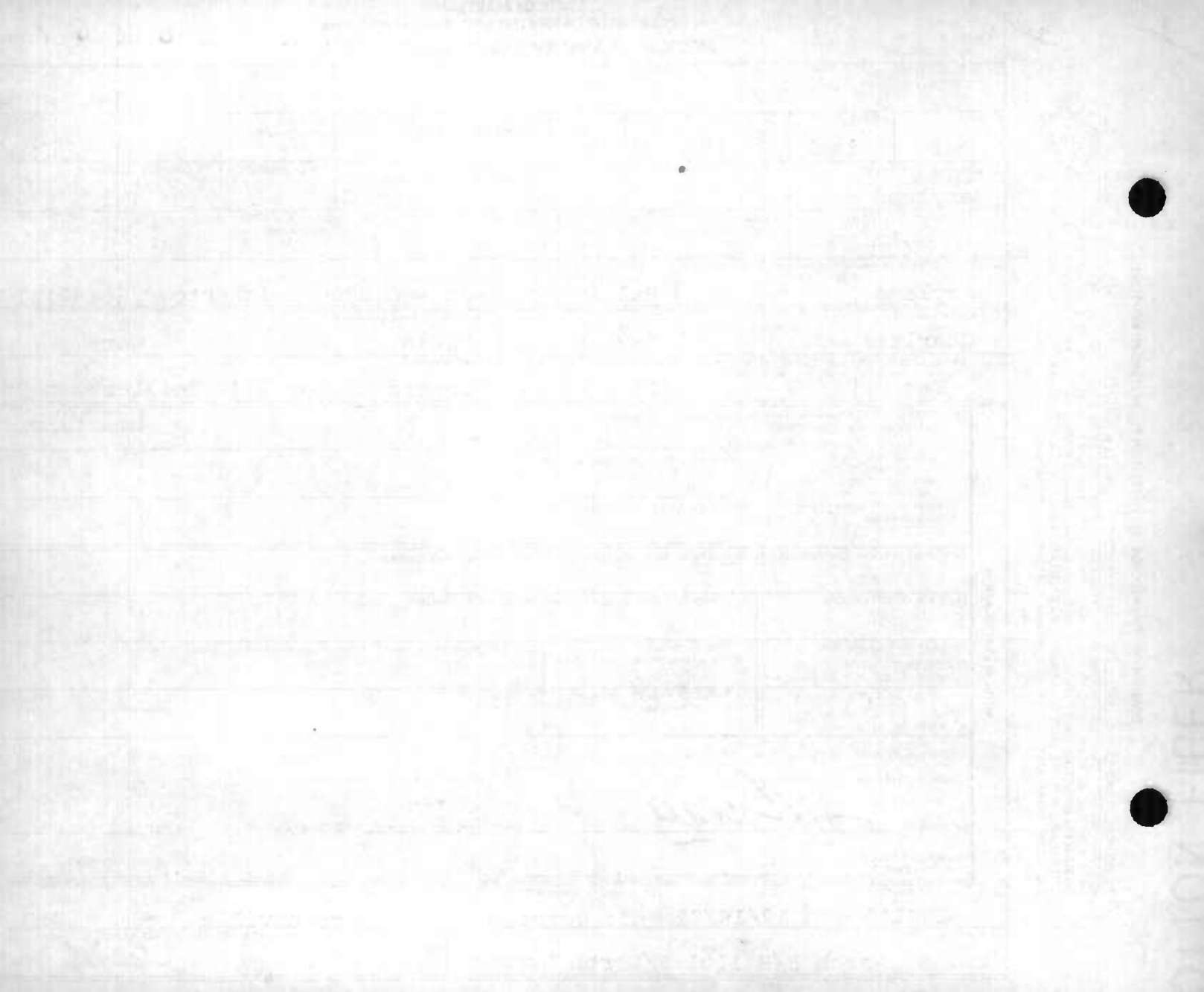
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. FORM 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2b. DATE KNOWN OF DEATH ESTIMATED		MONTH		DAY		YEAR		2d. HOUR	
Charles Taylor								X 10 11 19 82								M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
male	Black	5 10 26		56 YRS.						10 11 19 82						5:25P	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH								MD.	
Maryland		USA						Baltimore City									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		2800 Reisterstown Road															
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2800 Reistertown Road		21217							
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Charles Taylor		Mable Ware															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
Yes		225-20-9271		Francis Taylor		2340 Reistertown Rd											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		Chronic alcoholism		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
3030		DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF													
		(c)															
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY? (PA)		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)													
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on death resulted from:		Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		Autopsy <input checked="" type="checkbox"/> Partial <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion													
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		10/12/82											
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS															
Hornes R. Guard, M.D.		111 Penn Street, Balto., MD 21201															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN		COUNTY		STATE							
BURIAL		10/18/82		Md. Veteran Cem		Crownsville				Md.							
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Wm. C. March F/H		1101 E/North Avenue		OCT 14 1982		John J. Guard											



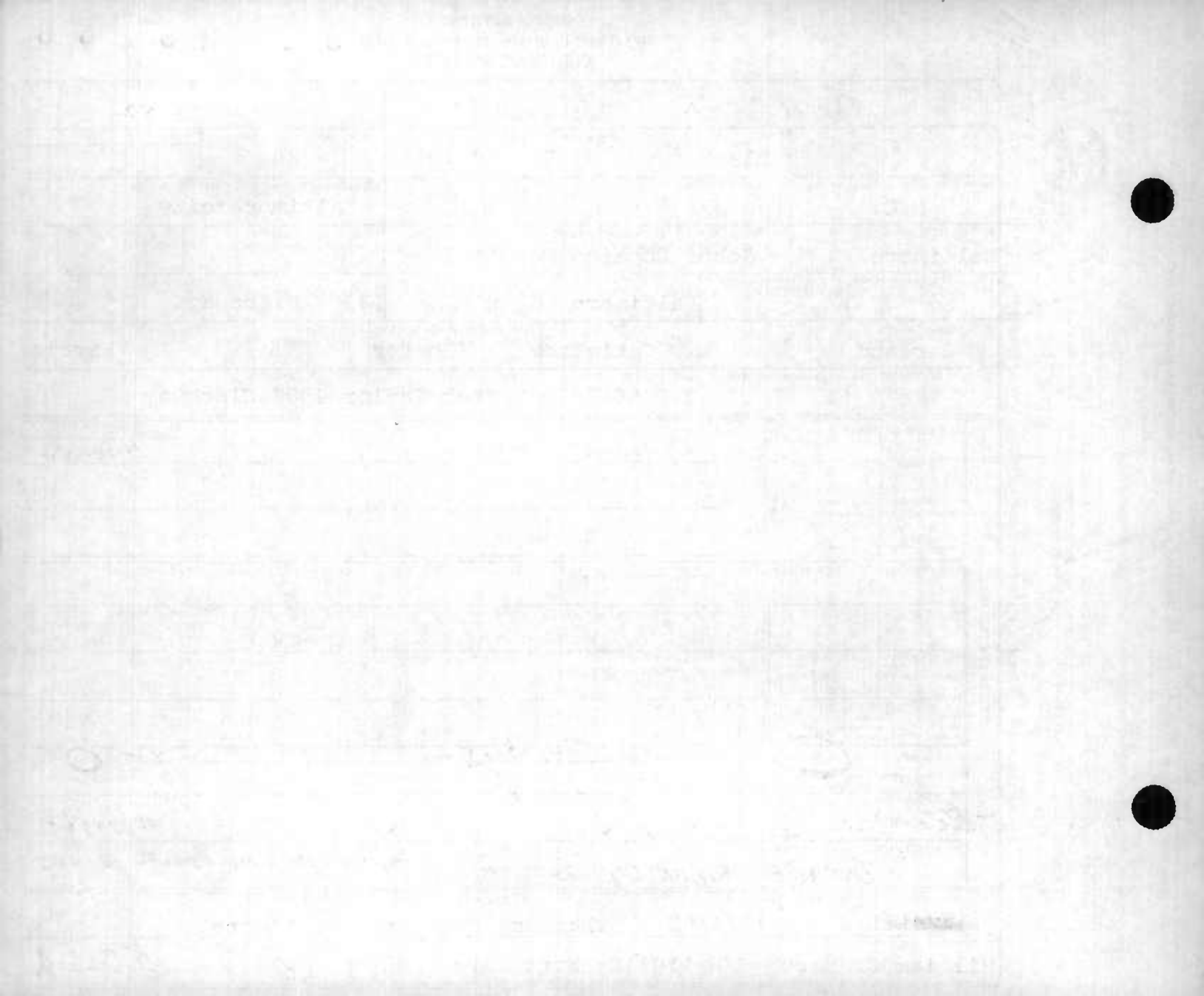
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 2 6 8

1- FOR
STATE
REGISTRAR

REG. NO.

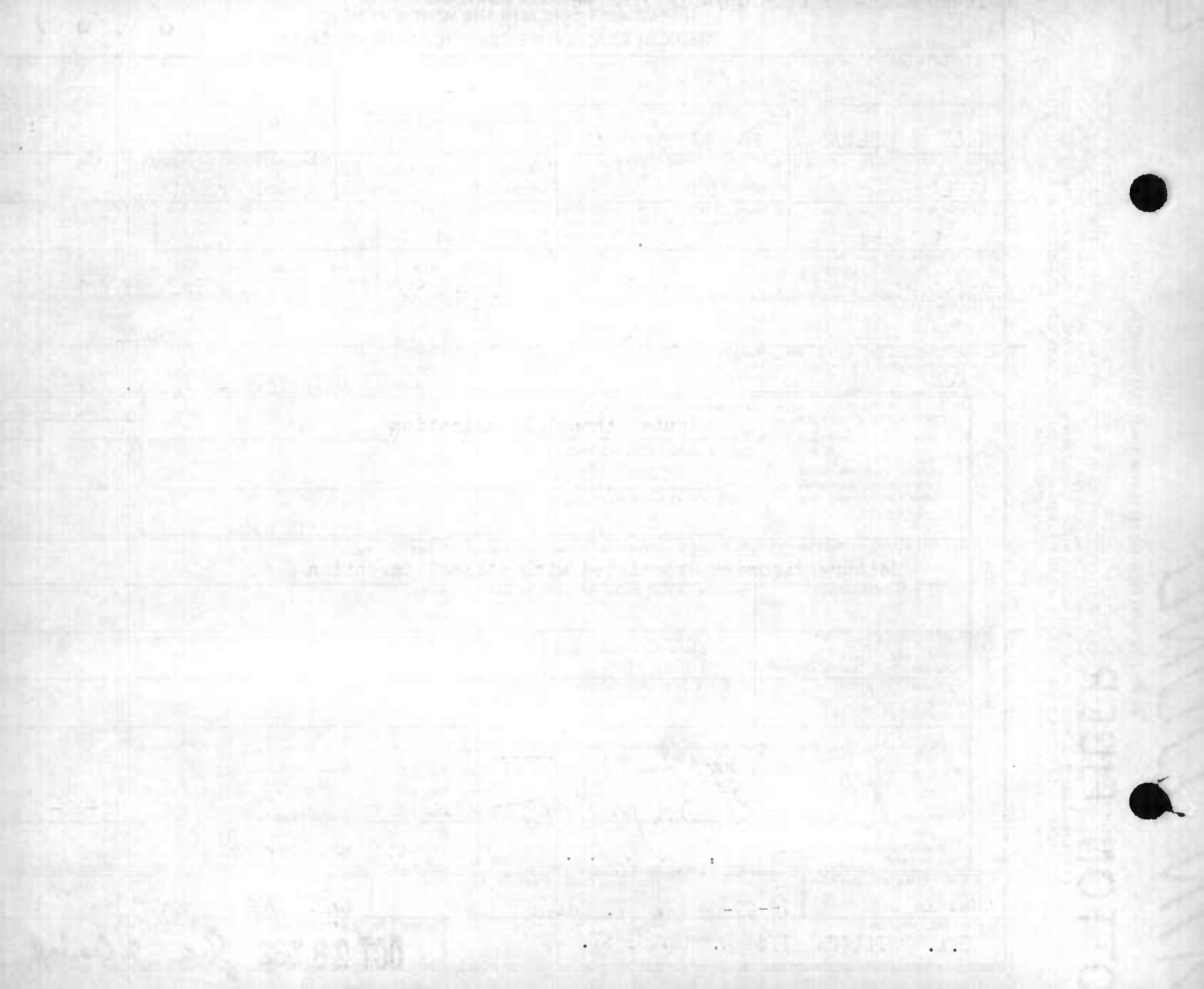
1. DECEASED NAME (TYPE OR PRINT) GRACE TAYLOR			2a. DATE OF DEATH MONTH DAY YEAR 10 28 82		2b. HOUR M
3 SEX F	4 RACE black	5. DATE OF BIRTH MONTH DAY YEAR 7 19 1942		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? U S A	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Md		13b. COUNTY Baltimore		13c. STREET ADDRESS 4308 Clareway	
14. FATHER'S NAME FIRST MIDDLE LAST Garland Catlette		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hester Harris			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 246-86-5670		17. INFORMANT ADDRESS Victor Taylor 4308 Clareway	
18. CAUSE OF DEATH. Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1809 CERVICAL CANCER IMMEDIATE CAUSE (a) CERVICAL CANCER DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 years
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		22a. I certify that (1) this hospital attended the deceased from 4/23/78 , 19____, to 10/11 , 19____, that (1) (we) lost saw the deceased on 10/28/82 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (1) (we) (did) (did not) view the body after death.			
22b. SIGNATURE Enrique Hernandez DEGREE		22c. DATE SIGNED 10/28/82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ENRIQUE HERNANDEZ, MD	
22e. ADDRESS Johns Hopkins Hospital Bldg 21205		23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			
23b. DATE 11/4/82		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md	
24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E, North Ave		25a. DATE REC'D. BY REGISTRAR NOV 1 1982		25b. REGISTRAR'S SIGNATURE John J. Connel	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, THE MEDICAL EXAMINER SHOULD EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. GIVE PAGES 4, 5, AND 6 TO THE MEDICAL EXAMINER. GIVE PAGES 7, 8, AND 9 TO THE FUNERAL DIRECTOR. GIVE PAGE 10 TO THE MEDICAL EXAMINER. GIVE PAGES 11, 12, AND 13 TO THE FUNERAL DIRECTOR. GIVE PAGES 14, 15, AND 16 TO THE MEDICAL EXAMINER. GIVE PAGES 17, 18, AND 19 TO THE FUNERAL DIRECTOR. GIVE PAGE 20 TO THE MEDICAL EXAMINER. GIVE PAGES 21, 22, AND 23 TO THE FUNERAL DIRECTOR. GIVE PAGES 24, 25, AND 26 TO THE MEDICAL EXAMINER. GIVE PAGES 27, 28, AND 29 TO THE FUNERAL DIRECTOR. GIVE PAGE 30 TO THE MEDICAL EXAMINER. GIVE PAGES 31, 32, AND 33 TO THE FUNERAL DIRECTOR. GIVE PAGES 34, 35, AND 36 TO THE MEDICAL EXAMINER. GIVE PAGES 37, 38, AND 39 TO THE FUNERAL DIRECTOR. GIVE PAGE 40 TO THE MEDICAL EXAMINER. GIVE PAGES 41, 42, AND 43 TO THE FUNERAL DIRECTOR. GIVE PAGES 44, 45, AND 46 TO THE MEDICAL EXAMINER. GIVE PAGES 47, 48, AND 49 TO THE FUNERAL DIRECTOR. GIVE PAGE 50 TO THE MEDICAL EXAMINER. GIVE PAGES 51, 52, AND 53 TO THE FUNERAL DIRECTOR. GIVE PAGES 54, 55, AND 56 TO THE MEDICAL EXAMINER. GIVE PAGES 57, 58, AND 59 TO THE FUNERAL DIRECTOR. GIVE PAGE 60 TO THE MEDICAL EXAMINER. GIVE PAGES 61, 62, AND 63 TO THE FUNERAL DIRECTOR. GIVE PAGES 64, 65, AND 66 TO THE MEDICAL EXAMINER. GIVE PAGES 67, 68, AND 69 TO THE FUNERAL DIRECTOR. GIVE PAGE 70 TO THE MEDICAL EXAMINER. GIVE PAGES 71, 72, AND 73 TO THE FUNERAL DIRECTOR. GIVE PAGES 74, 75, AND 76 TO THE MEDICAL EXAMINER. GIVE PAGES 77, 78, AND 79 TO THE FUNERAL DIRECTOR. GIVE PAGE 80 TO THE MEDICAL EXAMINER. GIVE PAGES 81, 82, AND 83 TO THE FUNERAL DIRECTOR. GIVE PAGES 84, 85, AND 86 TO THE MEDICAL EXAMINER. GIVE PAGES 87, 88, AND 89 TO THE FUNERAL DIRECTOR. GIVE PAGE 90 TO THE MEDICAL EXAMINER. GIVE PAGES 91, 92, AND 93 TO THE FUNERAL DIRECTOR. GIVE PAGES 94, 95, AND 96 TO THE MEDICAL EXAMINER. GIVE PAGES 97, 98, AND 99 TO THE FUNERAL DIRECTOR. GIVE PAGE 100 TO THE MEDICAL EXAMINER. GIVE PAGES 101, 102, AND 103 TO THE FUNERAL DIRECTOR. GIVE PAGES 104, 105, AND 106 TO THE MEDICAL EXAMINER. GIVE PAGES 107, 108, AND 109 TO THE FUNERAL DIRECTOR. GIVE PAGE 110 TO THE MEDICAL EXAMINER. GIVE PAGES 111, 112, AND 113 TO THE FUNERAL DIRECTOR. GIVE PAGES 114, 115, AND 116 TO THE MEDICAL EXAMINER. GIVE PAGES 117, 118, AND 119 TO THE FUNERAL DIRECTOR. GIVE PAGE 120 TO THE MEDICAL EXAMINER. GIVE PAGES 121, 122, AND 123 TO THE FUNERAL DIRECTOR. GIVE PAGES 124, 125, AND 126 TO THE MEDICAL EXAMINER. GIVE PAGES 127, 128, AND 129 TO THE FUNERAL DIRECTOR. GIVE PAGE 130 TO THE MEDICAL EXAMINER. GIVE PAGES 131, 132, AND 133 TO THE FUNERAL DIRECTOR. GIVE PAGES 134, 135, AND 136 TO THE MEDICAL EXAMINER. GIVE PAGES 137, 138, AND 139 TO THE FUNERAL DIRECTOR. GIVE PAGE 140 TO THE MEDICAL EXAMINER. GIVE PAGES 141, 142, AND 143 TO THE FUNERAL DIRECTOR. GIVE PAGES 144, 145, AND 146 TO THE MEDICAL EXAMINER. GIVE PAGES 147, 148, AND 149 TO THE FUNERAL DIRECTOR. GIVE PAGE 150 TO THE MEDICAL EXAMINER. GIVE PAGES 151, 152, AND 153 TO THE FUNERAL DIRECTOR. GIVE PAGES 154, 155, AND 156 TO THE MEDICAL EXAMINER. GIVE PAGES 157, 158, AND 159 TO THE FUNERAL DIRECTOR. GIVE PAGE 160 TO THE MEDICAL EXAMINER. GIVE PAGES 161, 162, AND 163 TO THE FUNERAL DIRECTOR. GIVE PAGES 164, 165, AND 166 TO THE MEDICAL EXAMINER. GIVE PAGES 167, 168, AND 169 TO THE FUNERAL DIRECTOR. GIVE PAGE 170 TO THE MEDICAL EXAMINER. GIVE PAGES 171, 172, AND 173 TO THE FUNERAL DIRECTOR. GIVE PAGES 174, 175, AND 176 TO THE MEDICAL EXAMINER. GIVE PAGES 177, 178, AND 179 TO THE FUNERAL DIRECTOR. GIVE PAGE 180 TO THE MEDICAL EXAMINER. GIVE PAGES 181, 182, AND 183 TO THE FUNERAL DIRECTOR. GIVE PAGES 184, 185, AND 186 TO THE MEDICAL EXAMINER. GIVE PAGES 187, 188, AND 189 TO THE FUNERAL DIRECTOR. GIVE PAGE 190 TO THE MEDICAL EXAMINER. GIVE PAGES 191, 192, AND 193 TO THE FUNERAL DIRECTOR. GIVE PAGES 194, 195, AND 196 TO THE MEDICAL EXAMINER. GIVE PAGES 197, 198, AND 199 TO THE FUNERAL DIRECTOR. GIVE PAGE 200 TO THE MEDICAL EXAMINER. GIVE PAGES 201, 202, AND 203 TO THE FUNERAL DIRECTOR. GIVE PAGES 204, 205, AND 206 TO THE MEDICAL EXAMINER. GIVE PAGES 207, 208, AND 209 TO THE FUNERAL DIRECTOR. GIVE PAGE 210 TO THE MEDICAL EXAMINER. GIVE PAGES 211, 212, AND 213 TO THE FUNERAL DIRECTOR. GIVE PAGES 214, 215, AND 216 TO THE MEDICAL EXAMINER. GIVE PAGES 217, 218, AND 219 TO THE FUNERAL DIRECTOR. GIVE PAGE 220 TO THE MEDICAL EXAMINER. GIVE PAGES 221, 222, AND 223 TO THE FUNERAL DIRECTOR. GIVE PAGES 224, 225, AND 226 TO THE MEDICAL EXAMINER. GIVE PAGES 227, 228, AND 229 TO THE FUNERAL DIRECTOR. GIVE PAGE 230 TO THE MEDICAL EXAMINER. GIVE PAGES 231, 232, AND 233 TO THE FUNERAL DIRECTOR. GIVE PAGES 234, 235, AND 236 TO THE MEDICAL EXAMINER. GIVE PAGES 237, 238, AND 239 TO THE FUNERAL DIRECTOR. GIVE PAGE 240 TO THE MEDICAL EXAMINER. GIVE PAGES 241, 242, AND 243 TO THE FUNERAL DIRECTOR. GIVE PAGES 244, 245, AND 246 TO THE MEDICAL EXAMINER. GIVE PAGES 247, 248, AND 249 TO THE FUNERAL DIRECTOR. GIVE PAGE 250 TO THE MEDICAL EXAMINER. GIVE PAGES 251, 252, AND 253 TO THE FUNERAL DIRECTOR. GIVE PAGES 254, 255, AND 256 TO THE MEDICAL EXAMINER. GIVE PAGES 257, 258, AND 259 TO THE FUNERAL DIRECTOR. GIVE PAGE 260 TO THE MEDICAL EXAMINER. GIVE PAGES 261, 262, AND 263 TO THE FUNERAL DIRECTOR. GIVE PAGES 264, 265, AND 266 TO THE MEDICAL EXAMINER. GIVE PAGES 267, 268, AND 269 TO THE FUNERAL DIRECTOR. GIVE PAGE 270 TO THE MEDICAL EXAMINER. GIVE PAGES 271, 272, AND 273 TO THE FUNERAL DIRECTOR. GIVE PAGES 274, 275, AND 276 TO THE MEDICAL EXAMINER. GIVE PAGES 277, 278, AND 279 TO THE FUNERAL DIRECTOR. GIVE PAGE 280 TO THE MEDICAL EXAMINER. GIVE PAGES 281, 282, AND 283 TO THE FUNERAL DIRECTOR. GIVE PAGES 284, 285, AND 286 TO THE MEDICAL EXAMINER. GIVE PAGES 287, 288, AND 289 TO THE FUNERAL DIRECTOR. GIVE PAGE 290 TO THE MEDICAL EXAMINER. GIVE PAGES 291, 292, AND 293 TO THE FUNERAL DIRECTOR. GIVE PAGES 294, 295, AND 296 TO THE MEDICAL EXAMINER. GIVE PAGES 297, 298, AND 299 TO THE FUNERAL DIRECTOR. GIVE PAGE 300 TO THE MEDICAL EXAMINER. GIVE PAGES 301, 302, AND 303 TO THE FUNERAL DIRECTOR. GIVE PAGES 304, 305, AND 306 TO THE MEDICAL EXAMINER. GIVE PAGES 307, 308, AND 309 TO THE FUNERAL DIRECTOR. GIVE PAGE 310 TO THE MEDICAL EXAMINER. GIVE PAGES 311, 312, AND 313 TO THE FUNERAL DIRECTOR. GIVE PAGES 314, 315, AND 316 TO THE MEDICAL EXAMINER. GIVE PAGES 317, 318, AND 319 TO THE FUNERAL DIRECTOR. GIVE PAGE 320 TO THE MEDICAL EXAMINER. GIVE PAGES 321, 322, AND 323 TO THE FUNERAL DIRECTOR. GIVE PAGES 324, 325, AND 326 TO THE MEDICAL EXAMINER. GIVE PAGES 327, 328, AND 329 TO THE FUNERAL DIRECTOR. GIVE PAGE 330 TO THE MEDICAL EXAMINER. GIVE PAGES 331, 332, AND 333 TO THE FUNERAL DIRECTOR. GIVE PAGES 334, 335, AND 336 TO THE MEDICAL EXAMINER. GIVE PAGES 337, 338, AND 339 TO THE FUNERAL DIRECTOR. GIVE PAGE 340 TO THE MEDICAL EXAMINER. GIVE PAGES 341, 342, AND 343 TO THE FUNERAL DIRECTOR. GIVE PAGES 344, 345, AND 346 TO THE MEDICAL EXAMINER. GIVE PAGES 347, 348, AND 349 TO THE FUNERAL DIRECTOR. GIVE PAGE 350 TO THE MEDICAL EXAMINER. GIVE PAGES 351, 352, AND 353 TO THE FUNERAL DIRECTOR. GIVE PAGES 354, 355, AND 356 TO THE MEDICAL EXAMINER. GIVE PAGES 357, 358, AND 359 TO THE FUNERAL DIRECTOR. GIVE PAGE 360 TO THE MEDICAL EXAMINER. GIVE PAGES 361, 362, AND 363 TO THE FUNERAL DIRECTOR. GIVE PAGES 364, 365, AND 366 TO THE MEDICAL EXAMINER. GIVE PAGES 367, 368, AND 369 TO THE FUNERAL DIRECTOR. GIVE PAGE 370 TO THE MEDICAL EXAMINER. GIVE PAGES 371, 372, AND 373 TO THE FUNERAL DIRECTOR. GIVE PAGES 374, 375, AND 376 TO THE MEDICAL EXAMINER. GIVE PAGES 377, 378, AND 379 TO THE FUNERAL DIRECTOR. GIVE PAGE 380 TO THE MEDICAL EXAMINER. GIVE PAGES 381, 382, AND 383 TO THE FUNERAL DIRECTOR. GIVE PAGES 384, 385, AND 386 TO THE MEDICAL EXAMINER. GIVE PAGES 387, 388, AND 389 TO THE FUNERAL DIRECTOR. GIVE PAGE 390 TO THE MEDICAL EXAMINER. GIVE PAGES 391, 392, AND 393 TO THE FUNERAL DIRECTOR. GIVE PAGES 394, 395, AND 396 TO THE MEDICAL EXAMINER. GIVE PAGES 397, 398, AND 399 TO THE FUNERAL DIRECTOR. GIVE PAGE 400 TO THE MEDICAL EXAMINER. GIVE PAGES 401, 402, AND 403 TO THE FUNERAL DIRECTOR. GIVE PAGES 404, 405, AND 406 TO THE MEDICAL EXAMINER. GIVE PAGES 407, 408, AND 409 TO THE FUNERAL DIRECTOR. GIVE PAGE 410 TO THE MEDICAL EXAMINER. GIVE PAGES 411, 412, AND 413 TO THE FUNERAL DIRECTOR. GIVE PAGES 414, 415, AND 416 TO THE MEDICAL EXAMINER. GIVE PAGES 417, 418, AND 419 TO THE FUNERAL DIRECTOR. GIVE PAGE 420 TO THE MEDICAL EXAMINER. GIVE PAGES 421, 422, AND 423 TO THE FUNERAL DIRECTOR. GIVE PAGES 424, 425, AND 426 TO THE MEDICAL EXAMINER. 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GIVE PAGE 570 TO THE MEDICAL EXAMINER. GIVE PAGES 571, 572, AND 573 TO THE FUNERAL DIRECTOR. GIVE PAGES 574, 575, AND 576 TO THE MEDICAL EXAMINER. GIVE PAGES 577, 578, AND 579 TO THE FUNERAL DIRECTOR. GIVE PAGE 580 TO THE MEDICAL EXAMINER. GIVE PAGES 581, 582, AND 583 TO THE FUNERAL DIRECTOR. GIVE PAGES 584, 585, AND 586 TO THE MEDICAL EXAMINER. GIVE PAGES 587, 588, AND 589 TO THE FUNERAL DIRECTOR. GIVE PAGE 590 TO THE MEDICAL EXAMINER. GIVE PAGES 591, 592, AND 593 TO THE FUNERAL DIRECTOR. GIVE PAGES 594, 595, AND 596 TO THE MEDICAL EXAMINER. GIVE PAGES 597, 598, AND 599 TO THE FUNERAL DIRECTOR. GIVE PAGE 600 TO THE MEDICAL EXAMINER. GIVE PAGES 601, 602, AND 603 TO THE FUNERAL DIRECTOR. GIVE PAGES 604, 605, AND 606 TO THE MEDICAL EXAMINER. GIVE PAGES 607, 608, AND 609 TO THE FUNERAL DIRECTOR. GIVE PAGE 610 TO THE MEDICAL EXAMINER. GIVE PAGES 611, 612, AND 613 TO THE FUNERAL DIRECTOR. GIVE PAGES 614, 615, AND 616 TO THE MEDICAL EXAMINER. GIVE PAGES 617, 618, AND 619 TO THE FUNERAL DIRECTOR. GIVE PAGE 620 TO THE MEDICAL EXAMINER. GIVE PAGES 621, 622, AND 623 TO THE FUNERAL DIRECTOR. GIVE PAGES 624, 625, AND 626 TO THE MEDICAL EXAMINER. GIVE PAGES 627, 628, AND 629 TO THE FUNERAL DIRECTOR. GIVE PAGE 630 TO THE MEDICAL EXAMINER. GIVE PAGES 631, 632, AND 633 TO THE FUNERAL DIRECTOR. GIVE PAGES 634, 635, AND 636 TO THE MEDICAL EXAMINER. GIVE PAGES 637, 638, AND 639 TO THE FUNERAL DIRECTOR. GIVE PAGE 640 TO THE MEDICAL EXAMINER. GIVE PAGES 641, 642, AND 643 TO THE FUNERAL DIRECTOR. GIVE PAGES 644, 645, AND 646 TO THE MEDICAL EXAMINER. GIVE PAGES 647, 648, AND 649 TO THE FUNERAL DIRECTOR. GIVE PAGE 650 TO THE MEDICAL EXAMINER. GIVE PAGES 651, 652, AND 653 TO THE FUNERAL DIRECTOR. GIVE PAGES 654, 655, AND 656 TO THE MEDICAL EXAMINER. GIVE PAGES 657, 658, AND 659 TO THE FUNERAL DIRECTOR. GIVE PAGE 660 TO THE MEDICAL EXAMINER. GIVE PAGES 661, 662, AND 663 TO THE FUNERAL DIRECTOR. GIVE PAGES 664, 665, AND 666 TO THE MEDICAL EXAMINER. GIVE PAGES 667, 668, AND 669 TO THE FUNERAL DIRECTOR. GIVE PAGE 670 TO THE MEDICAL EXAMINER. GIVE PAGES 671, 672, AND 673 TO THE FUNERAL DIRECTOR. GIVE PAGES 674, 675, AND 676 TO THE MEDICAL EXAMINER. GIVE PAGES 677, 678, AND 679 TO THE FUNERAL DIRECTOR. GIVE PAGE 680 TO THE MEDICAL EXAMINER. GIVE PAGES 681, 682, AND 683 TO THE FUNERAL DIRECTOR. GIVE PAGES 684, 685, AND 686 TO THE MEDICAL EXAMINER. GIVE PAGES 687, 688, AND 689 TO THE FUNERAL DIRECTOR. GIVE PAGE 690 TO THE MEDICAL EXAMINER. GIVE PAGES 691, 692, AND 693 TO THE FUNERAL DIRECTOR. GIVE PAGES 694, 695, AND 696 TO THE MEDICAL EXAMINER. GIVE PAGES 697, 698, AND 699 TO THE FUNERAL DIRECTOR. GIVE PAGE 700 TO THE MEDICAL EXAMINER. GIVE PAGES 701, 702, AND 703 TO THE FUNERAL DIRECTOR. GIVE PAGES 704, 705, AND 706 TO THE MEDICAL EXAMINER. GIVE PAGES 707, 708, AND 709 TO THE FUNERAL DIRECTOR. GIVE PAGE 710 TO THE MEDICAL EXAMINER. GIVE PAGES 711, 712, AND 713 TO THE FUNERAL DIRECTOR. GIVE PAGES 714, 715, AND 716 TO THE MEDICAL EXAMINER. GIVE PAGES 717, 718, AND 719 TO THE FUNERAL DIRECTOR. GIVE PAGE 720 TO THE MEDICAL EXAMINER. GIVE PAGES 721, 722, AND 723 TO THE FUNERAL DIRECTOR. GIVE PAGES 724, 725, AND 726 TO THE MEDICAL EXAMINER. GIVE PAGES 727, 728, AND 729 TO THE FUNERAL DIRECTOR. GIVE PAGE 730 TO THE MEDICAL EXAMINER. GIVE PAGES 731, 732, AND 733 TO THE FUNERAL DIRECTOR. GIVE PAGES 734, 735, AND 736 TO THE MEDICAL EXAMINER. GIVE PAGES 737, 738, AND 739 TO THE FUNERAL DIRECTOR. GIVE PAGE 740 TO THE MEDICAL EXAMINER. GIVE PAGES 741, 742, AND 743 TO THE FUNERAL DIRECTOR. GIVE PAGES 744, 745, AND 746 TO THE MEDICAL EXAMINER. GIVE PAGES 747, 748, AND 749 TO THE FUNERAL DIRECTOR. GIVE PAGE 750 TO THE MEDICAL EXAMINER. GIVE PAGES 751, 752, AND 753 TO THE FUNERAL DIRECTOR. GIVE PAGES 754, 755, AND 756 TO THE MEDICAL EXAMINER. GIVE PAGES 757, 758, AND 759 TO THE FUNERAL DIRECTOR. GIVE PAGE 760 TO THE MEDICAL EXAMINER. GIVE PAGES 761, 762, AND 763 TO THE FUNERAL DIRECTOR. GIVE PAGES 764, 765, AND 766 TO THE MEDICAL EXAMINER. GIVE PAGES 767, 768, AND 769 TO THE FUNERAL DIRECTOR. GIVE PAGE 770 TO THE MEDICAL EXAMINER. GIVE PAGES 771, 772, AND 773 TO THE FUNERAL DIRECTOR. GIVE PAGES 774, 775, AND 776 TO THE MEDICAL EXAMINER. GIVE PAGES 777, 778, AND 779 TO THE FUNERAL DIRECTOR. GIVE PAGE 780 TO THE MEDICAL EXAMINER. GIVE PAGES 781, 782, AND 783 TO THE FUNERAL DIRECTOR. GIVE PAGES 784, 785, AND 786 TO THE MEDICAL EXAMINER. GIVE PAGES 787, 788, AND 789 TO THE FUNERAL DIRECTOR. GIVE PAGE 790 TO THE MEDICAL EXAMINER. GIVE PAGES 791, 792, AND 793 TO THE FUNERAL DIRECTOR. GIVE PAGES 794, 795, AND 796 TO THE MEDICAL EXAMINER. GIVE PAGES 797, 798, AND 799 TO THE FUNERAL DIRECTOR. GIVE PAGE 800 TO THE MEDICAL EXAMINER. GIVE PAGES 801, 802, AND 803 TO THE FUNERAL DIRECTOR. GIVE PAGES 804, 805, AND 806 TO THE MEDICAL EXAMINER. GIVE PAGES 807, 808, AND 809 TO THE FUNERAL DIRECTOR. GIVE PAGE 810 TO THE MEDICAL EXAMINER. GIVE PAGES 811, 812, AND 813 TO THE FUNERAL DIRECTOR. GIVE PAGES 814, 815, AND 816 TO THE MEDICAL EXAMINER. GIVE PAGES 817, 818, AND 819 TO THE FUNERAL DIRECTOR. GIVE PAGE 820 TO THE MEDICAL EXAMINER. GIVE PAGES 821, 822, AND 823 TO THE FUNERAL DIRECTOR. GIVE PAGES 824, 825, AND 826 TO THE MEDICAL EXAMINER. GIVE PAGES 827, 828, AND 829 TO THE FUNERAL DIRECTOR. GIVE PAGE 830 TO THE MEDICAL EXAMINER. GIVE PAGES 831, 832, AND 833 TO THE FUNERAL DIRECTOR. GIVE PAGES 834, 835, AND 836 TO THE MEDICAL EXAMINER. GIVE PAGES 837, 838, AND 839 TO THE FUNERAL DIRECTOR. GIVE PAGE 840 TO THE MEDICAL EXAMINER. GIVE PAGES 841, 842, AND 843 TO THE FUNERAL DIRECTOR. GIVE PAGES 844, 845, AND 846 TO THE MEDICAL EXAMINER. GIVE PAGES 847, 848, AND 849 TO THE FUNERAL DIRECTOR. GIVE PAGE 850 TO THE MEDICAL EXAMINER. GIVE PAGES 851, 852, AND 853 TO THE FUNERAL DIRECTOR. 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GIVE PAGES 901, 902, AND 903 TO THE FUNERAL DIRECTOR. GIVE PAGES 904, 905, AND 906 TO THE MEDICAL EXAMINER. GIVE PAGES 907, 908, AND 909 TO THE FUNERAL DIRECTOR. GIVE PAGE 910 TO THE MEDICAL EXAMINER. GIVE PAGES 911, 912, AND 913 TO THE FUNERAL DIRECTOR. GIVE PAGES 914, 915, AND 916 TO THE MEDICAL EXAMINER. GIVE PAGES 917, 918, AND 919 TO THE FUNERAL DIRECTOR. GIVE PAGE 920 TO THE MEDICAL EXAMINER. GIVE PAGES 921, 922, AND 923 TO THE FUNERAL DIRECTOR. GIVE PAGES 924, 925, AND 926 TO THE MEDICAL EXAMINER. GIVE PAGES 927, 928, AND 929 TO THE FUNERAL DIRECTOR. GIVE PAGE 930 TO THE MEDICAL EXAMINER. GIVE PAGES 931, 932, AND 933 TO THE FUNERAL DIRECTOR. GIVE PAGES 934, 935, AND 936 TO THE MEDICAL EXAMINER. GIVE PAGES 937, 938, AND 939 TO THE FUNERAL DIRECTOR. GIVE PAGE 940 TO THE MEDICAL EXAMINER. GIVE PAGES 941, 942, AND 943 TO THE FUNERAL DIRECTOR. GIVE PAGES 944, 945, AND 946 TO THE MEDICAL EXAMINER. GIVE PAGES 947, 948, AND 949 TO THE FUNERAL DIRECTOR. GIVE PAGE 950 TO THE MEDICAL EXAMINER. GIVE PAGES 951, 952, AND 953 TO THE FUNERAL DIRECTOR. GIVE PAGES 954, 955, AND 956 TO THE MEDICAL EXAMINER. GIVE PAGES 957, 958, AND 959 TO THE FUNERAL DIRECTOR. GIVE PAGE 960 TO THE MEDICAL EXAMINER. GIVE PAGES 961, 962, AND 963 TO THE FUNERAL DIRECTOR. GIVE PAGES 964, 965, AND 966 TO THE MEDICAL EXAMINER. GIVE PAGES 967, 968, AND 969 TO THE FUNERAL DIRECTOR. GIVE PAGE 970 TO THE MEDICAL EXAMINER. GIVE PAGES 971, 972, AND 973 TO THE FUNERAL DIRECTOR. GIVE PAGES 974, 975, AND 976 TO THE MEDICAL EXAMINER. GIVE PAGES 977, 978, AND 979 TO THE FUNERAL DIRECTOR. GIVE PAGE 980 TO THE MEDICAL EXAMINER. GIVE PAGES 981, 982, AND 983 TO THE FUNERAL DIRECTOR. GIVE PAGES 984, 985, AND 986 TO THE MEDICAL EXAMINER. GIVE PAGES 987, 988, AND 989 TO THE FUNERAL DIRECTOR. GIVE PAGE 990 TO THE MEDICAL EXAMINER. GIVE PAGES 991, 992, AND 993 TO THE FUNERAL DIRECTOR. GIVE PAGES 994, 995, AND 996 TO THE MEDICAL EXAMINER. GIVE PAGES 997, 998, AND 999 TO THE FUNERAL DIRECTOR. GIVE PAGE 1000 TO THE MEDICAL EXAMINER.

BP 344
DHMH - 17
(VR A15 ME (5))
20M 4/82

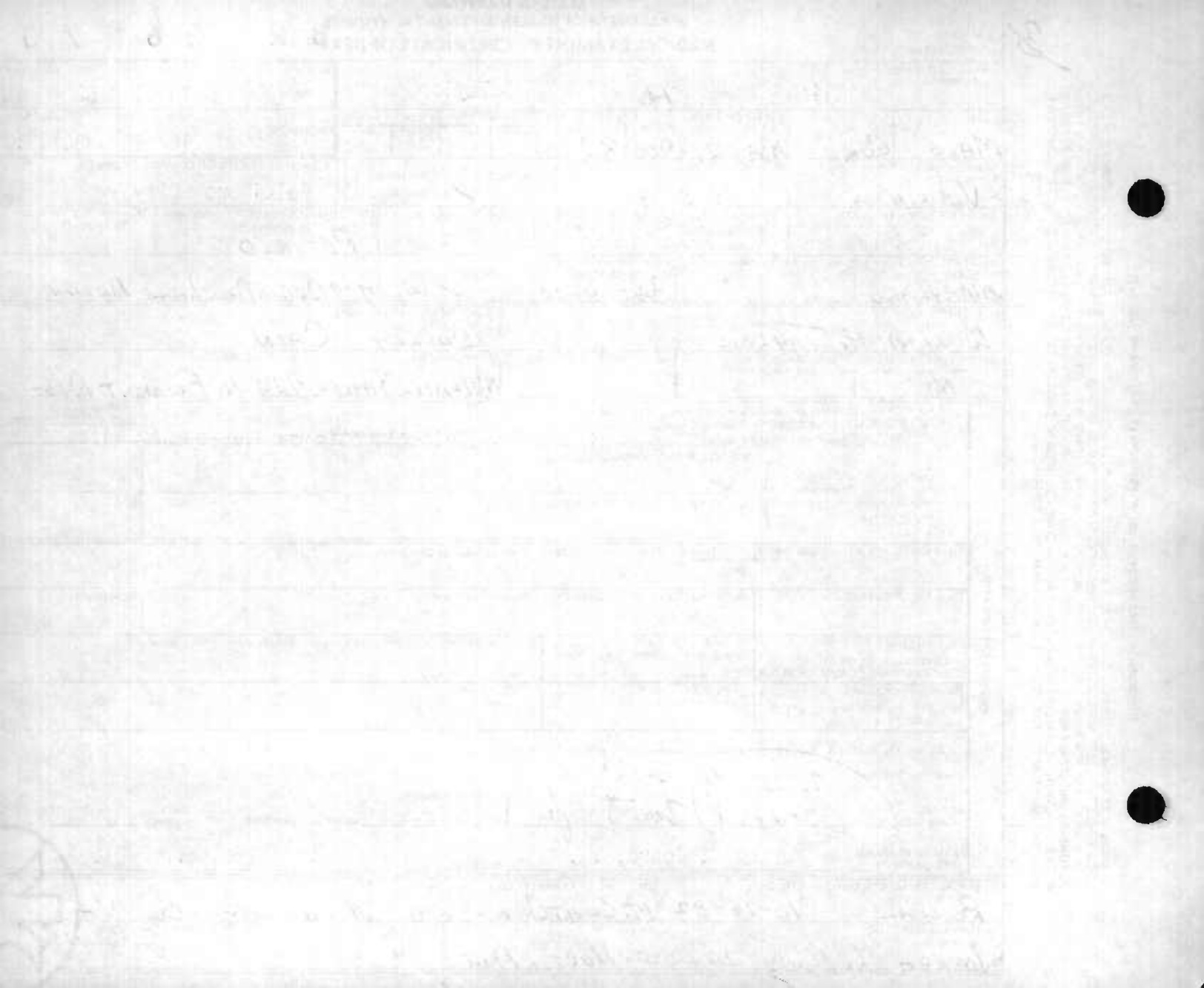
FOR 1- STATE REGISTRAR										2 2 6 2 6 9											
1. DECEASED NAME (TYPE OR PRINT)										2b. DATE KNOWN OF DEATH MATED											
James					Taylor					10 23 1982					2b. HOUR 3:51 a.m.						
2. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 10 24 39		6. AGE (IN YEARS) (LAST BIRTHDAY) 43 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 10 23 1982					2d. HOUR 3:51 a.m.				
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND					7b. CITIZEN OF WHAT COUNTRY? US					8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>					9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.						
10. CITY OR TOWN OF DEATH Baltimore					11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balto. General Hospital					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY						
13a. STATE MARYLAND										13b. COUNTY H.A.		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 710 NEWTOWN DRIVE 21401					
14. FATHER'S NAME FIRST MIDDLE LAST JOHN TAYLOR					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARIE JONES																
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES					16b. SOCIAL SECURITY NO.					17. INFORMANT SADIE CASTRUCCIO 100 REAVIS RD. 21076					ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART I DEATH WAS CAUSED BY: 3030 IMMEDIATE CAUSE (a) Acute Ethanol Intoxication Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) DUE TO, OR AS A CONSEQUENCE OF (c) DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Seizure disorder associated with ethanol ingestion																					
19a. DATE OF OPERATION					19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?					20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH					21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19					21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>					21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)					21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																					
ACTUAL SIGNATURE Dennis F. Smyth, M.D.					TITLE (SPECIFY) Assistant MEDICAL EXAMINER					DATE SIGNED 10-23-82											
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.					ADDRESS 111 Penn Street																
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL					23b. DATE 10-29-82					23c. NAME OF CEMETERY OR CREMATORY MT. CALVARY					23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND						
24. FUNERAL DIRECTOR E.L. PHILLIPS 1721 N. MONROE ST.					25a. DATE REC'D. BY REGISTRAR OCT 28 1982					25b. REGISTRAR'S SIGNATURE John J. Carver											



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26270	
1- FOR STATE REGISTRAR						2a. DATE KNOWN OF DEATH		2b. HOUR		2c. DATE OF DEATH	
1. DECEASED NAME (TYPE OR PRINT) William H. Taylor						2a. DATE KNOWN OF DEATH		2b. HOUR		2c. DATE OF DEATH	
3. SEX MALE		4. RACE COL		5. DATE OF BIRTH MONTH DAY YEAR MAY 2, 1900 82 YRS.		6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS.		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		7c. DATE PRONOUNCED DEAD 10 12 19 82 12:2	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIRGINIA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 727 Druid Park Lake Drive				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 727 DRUID PARK LAKE DRIVE			
14. FATHER'S NAME FIRST MIDDLE LAST William H. TAYLOR						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SALLEY CAIN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS DANIEL TAYLOR 729 N. FREMONT AVE					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertension and arteriosclerotic cardiovascular disease 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE		TITLE (SPECIFY) Assistant MEDICAL EXAMINER				DATE SIGNED		10/12/82			
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.		ADDRESS 111 Penn Street, Balto., MD 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-16-82		23c. NAME OF CEMETERY OR CREMATORY MT OLIVET CHURCH CEM				23d. LOCATION CITY OR TOWN COUNTY STATE NORTH HAVENLAND CO. VA			
24. FUNERAL DIRECTOR NAME JOSEPH L. RUGG		ADDRESS 2222 W. NORTH AVE		25a. DATE REC'D. BY REGISTRAR OCT 15 1982		25b. REGISTRAR'S SIGNATURE John J. Gahring					



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) MICHAEL B. THIR			2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10-24-82			2b. HOUR M 2:51P		
3. SEX Male	4. RACE Cauc.	5. DATE OF BIRTH MONTH DAY YEAR Jan. 1, 1965	6. AGE (IN YEARS) (LAST BIRTHDAY) 17 YRS.	IF UNDER 1 YR. MONTHS DAYS 17	IF UNDER 24 HRS. HOURS MIN. 17	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10-24-82		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? United States		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		
11. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital S.T.U.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY None
13a. STATE Maryland			13b. COUNTY Montgomery	13c. CITY OR TOWN Rockville	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS (20850) 213 North Van Buren Street		
14. FATHER'S NAME FIRST MIDDLE LAST Michael Francis Thir			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rose Marie Stahr					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) not available		17. INFORMANT ADDRESS Rose Marie Thir, same as #13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Head injury 8151 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? (HEAD ONLY) YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY MONTH DAY YEAR approx 7:30PM 10-23-82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) passenger in a pick-up truck which lost control striking a tree			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street		21f. LOCATION STREET CITY OR TOWN COUNTY STATE Secondary Rt.#32 Jefferson Co. West, Virginia			
22a. I certify that I took charge of the remains (HEAD ONLY) and Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Margarita A. Korell			TITLE (SPECIFY) Assistant			DATE SIGNED 10-25-82		
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.			ADDRESS 111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation			23b. DATE Oct 28, 1982		23c. NAME OF CEMETERY OR CREMATORY Metropolitan Crem.		23d. LOCATION CITY OR TOWN COUNTY STATE Alexandria, Virginia	
24. FUNERAL DIRECTOR NAME Robert A. Pumphrey Funeral Homes, P.A. Rockville, Maryland					25a. DATE REC'D. BY REGISTRAR OCT 29 1982		25b. REGISTRAR'S SIGNATURE John J. Coker	



NEW YORK
JAN 14 1901



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 6 2 7 2	
1. DECEASED NAME (TYPE OR PRINT)			FIRST DIANE		MIDDLE DIA N A		LAST THOMAS		2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 1 82		2b. HOUR M 9:20
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 5 25 45	6. AGE (IN YEARS) LAST BIRTHDAY 37 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 1 82		2d. HOUR M 9:20			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City			AM MD		
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 725 George St.			
14. FATHER'S NAME FIRST MIDDLE LAST Dabney			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Thomas Virginia Slater								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 218 44 2999		17. INFORMANT ADDRESS Delores White 3009 Ridgewood Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple stab wounds 9660 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12:15AM 10/1 19 82			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject stabbed					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> XX			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) apartment			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 725 George Street, Baltimore, MD					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Hormez R. Guard			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 10/1/82		
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.			ADDRESS 111 Penn Street, Balto., MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10-6-82		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem.			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Brown/Thompson F.H. 1913 W. Balto. St.						25a. DATE REC'D. BY REGISTRAR OCT 4 1982					
						25b. REGISTRAR'S SIGNATURE John J. Conner					

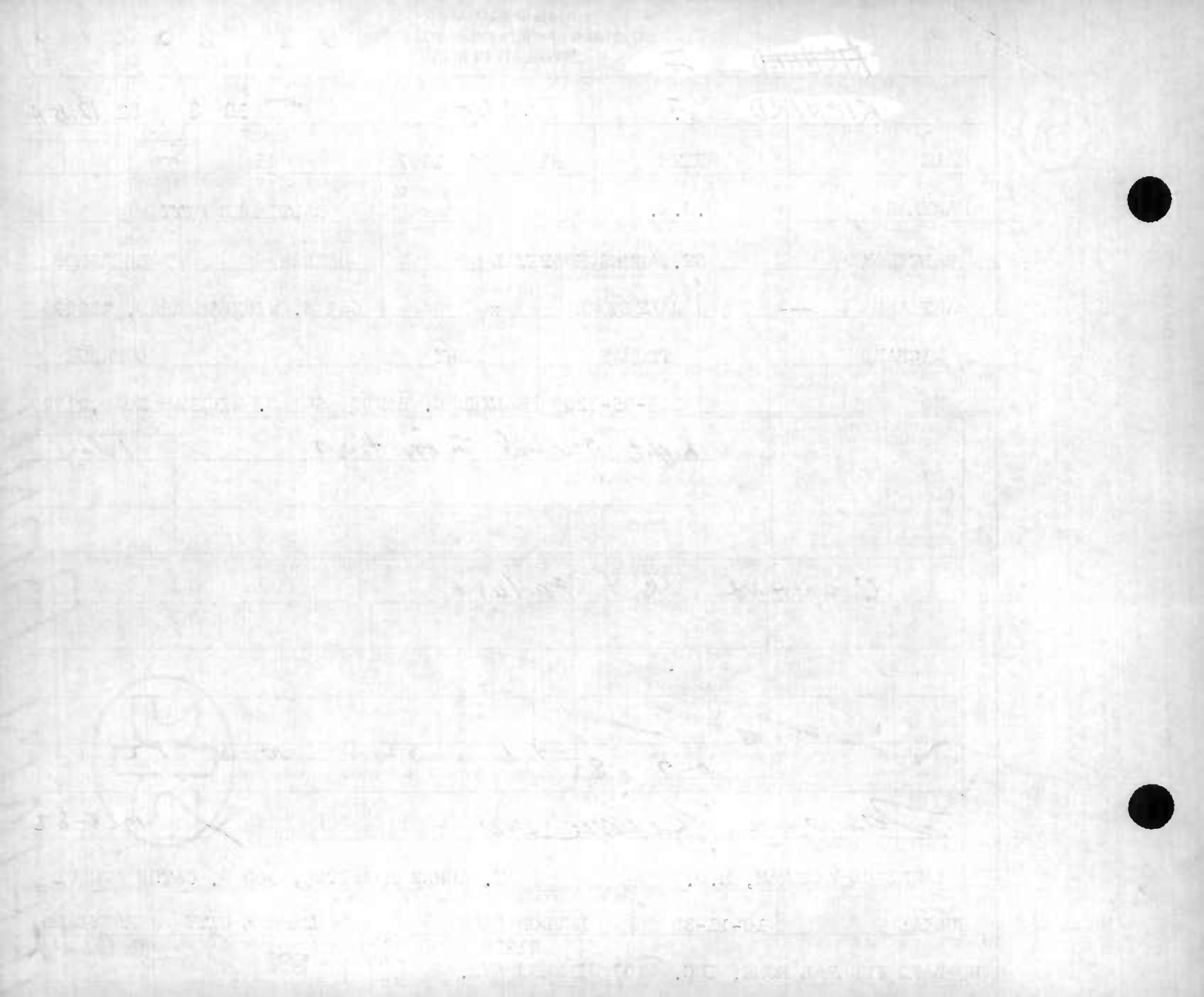
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages noted 2 should be filed with in 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 6 2 7 3			
FOR 1- STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RICHARD J. THOMAS				2a. DATE OF DEATH MONTH DAY YEAR 10 8 82 2b. HOUR 12:15 AM			
1. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 01 06 1897		6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) BARBER		12b. KIND OF BUSINESS OR INDUSTRY BARBERSHOP	
13a. STATE MARYLAND				13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE	
14. FATHER'S NAME FIRST MIDDLE LAST RICHARD				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY DONAHUE			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 216-05-3209		17. INFORMANT ADDRESS WALTER H. HANDS 641 S. WICKHAM ROAD, 21229	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Right Cerebral Infection 4349 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Congestive Heart Failure							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9-1 19 82 , to 10-8 19 82 , that (I) (we) last saw the deceased alive on 10-7 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Lawrence Zeidman M.D.				DEGREE M.D.		22c. DATE SIGNED 10-8-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAWRENCE ZEIDMAN, M.D.				22e. ADDRESS ST. AGNES HOSPITAL, 900 S. CATON AVENUE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-11-82		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR NAME HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE.				25a. DATE REC'D. BY REGISTRAR OCT 11 1982		25b. REGISTRAR'S SIGNATURE John J. Smith	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner or public health nurse must be notified.1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 2 7 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Anna B. Thompson			2a. DATE OF DEATH MONTH 10 DAY 12 YEAR 1982			2b. HOUR M					
3. SEX female		4. RACE black		5. DATE OF BIRTH MONTH 7 DAY 17 YEAR 1924		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. C.		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4240 Park Heights Avenue			
14. FATHER'S NAME FIRST Will MIDDLE LAST Booker				15. MOTHER'S MAIDEN NAME FIRST Laura MIDDLE LAST Hunter							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. 247-52-3713		17. INFORMANT ADDRESS Mary Ford 4240 Park Heights Avenue							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4019 IMMEDIATE CAUSE (a) Severe Dehydration DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Supper toxin Vasculitis DUE TO, OR AS A CONSEQUENCE OF (c) Intestinal Vermin APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 2						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> VOLUNTARILY AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 1983 , 19 10/12/82 , to 10/18/82 , that (I) (we) last saw the deceased alive on 19 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE WAYLAND E. JONES, M.D. DEGREE PHYSICIAN AND SURGEON						22c. DATE SIGNED 10/18/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) 1300 N. FREMONT AVE.						22e. ADDRESS 2200					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/19/82		23c. NAME OF CEMETERY OR CREMATORY Mt Calvary Cem			23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co Md			
24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Ave						25a. DATE REC'D. BY REGISTRAR OCT 18 1982		25b. REGISTRAR'S SIGNATURE John J. Connel			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 2 7 5

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) George W Thompson			2a. DATE OF DEATH MONTH DAY YEAR 10 08 82			2b. HOUR 6:22 A M				
3. SEX Male		4. RACE Black-		5. DATE OF BIRTH MONTH DAY YEAR 7 12 '18		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 726 Beaverbrook Rd			
14. FATHER'S NAME FIRST MIDDLE LAST Charles Thompson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Smith			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) Yes			16b. SOCIAL SECURITY NO. 219-03-3534	
17. INFORMANT ADDRESS 726 Beaverbrook			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROFOUND ACIDOSIS 0389 DUE TO, OR AS A CONSEQUENCE OF (b) SEPSIS Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) DUE TO, OR AS A CONSEQUENCE OF			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: ACUTE RENAL FAILURE; ADULT ONSET DIABETES MELLITUS										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 4/25 82 to 10/6 82				
22a. I certify that (I) (this hospital) attended the deceased from 10/6 82 to 10/6 82, that (I) (we) last saw the deceased alive on 10/6 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Stephen K. Dyak, MD			DEGREE			ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/6/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Stephen K. Dyak			22e. ADDRESS 5501 Lasalle Rd Towson MD 21204							

MEDICAL CERTIFICATION

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/11/82		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. PK		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus, Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Ave.				25a. DATE REC'D. BY REGISTRAR OCT 7 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	

20% COTTON

CHILLER



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

FOR: ITEM 19 film 573										DEPARTMENT OF HEALTH AND MENTAL HYGIENE										MEDICAL EXAMINER'S CERTIFICATE OF DEATH																			
1- STATE REGISTRAR 11-8-82 cn										REG. NO. 2 26276																													
1. DECEASED NAME (TYPE OR PRINT) Palmer Thompson										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 10 DAY 1 YEAR 1982										2b. HOUR 8:00 AM																			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH 6 DAY 14 YEAR 19		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH 10 DAY 1 YEAR 1982										2d. HOUR 8:00 AM																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Tennessee				7b. CITIZEN OF WHAT COUNTRY? U.S.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City										MD.																	
11. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN U.S. FACILITY, GIVE STREET ADDRESS) 1107 W. 36th Street								12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sheetmetal								12b. KIND OF BUSINESS OR INDUSTRY Shipyard																			
13a. STATE Md.										13b. COUNTY Balto.										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>										13e. STREET ADDRESS 1107 W. 36th St.									
14. FATHER'S NAME FIRST MIDDLE LAST Robert Sherman Thompson										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST																													
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes										16b. SOCIAL SECURITY NO. WWII 401-26-1124										17. INFORMANT ADDRESS Robert M. Thompson (Same as #13)																			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Asphyxia from food bolus 9110 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Acute ethanol intoxication																																							
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? XX 10/1 1982										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) while eating																			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home										21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1107 W. 36th Street, Baltimore, MD																			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										TITLE (SPECIFY) M.D. Assistant										DATE SIGNED 10/1/82																			
ACTUAL SIGNATURE <i>H.R. Guard</i>										EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.										ADDRESS 111 Penn Street, Balto., MD 21201																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal										23b. DATE 10/7/82										23c. NAME OF CEMETERY OR CREMATORY										23d. LOCATION CITY OR TOWN COUNTY STATE									
24. FUNERAL DIRECTOR NAME Anatomy Board										ADDRESS Balto., Md.										25a. DATE REC'D. BY REGISTRAR OCT 18 1982										25b. REGISTRAR'S SIGNATURE <i>John J. Conner</i>									

10-1-50
10-1-50
10-1-50

State Police

Chambers

Prisoner

Identification

Subject

Arrest

File

10-1-50

10-1-50

10-1-50

10-1-50

10-1-50

10-1-50



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 2 7 7	
FOR 1. STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BESSIE A THORNTON					2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 08, 1982			2b. HOUR 06:53 PM			
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 6 15 12		6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.			
8a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		8b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland					13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME FIRST MIDDLE LAST Willie Ogburn					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Amy Reed						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 227-14-9945		17. INFORMANT ADDRESS Vivian E. Moore 703 Wharton Ct. 21205							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: 1790 IMMEDIATE CAUSE (a) Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) uterine cancer DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hour 2 years											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Renal failure, gastrointestinal bleeding											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9/14 , 19 82 , to 10/8 , 19 82 , that (I) (we) last saw the deceased alive on 10/8 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Patricia A Tewes		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10-9-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Patricia A Tewes				22e. ADDRESS 601 N Wolfe St							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/13/82		23c. NAME OF CEMETERY OR CREMATORY Balto. National		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.					
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue				25. DATE REC'D. BY REGISTRAR OCT 11 1982		25. REGISTRAR'S SIGNATURE John J. Carver					

TID FRONTIER

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 8 2 2 6 2 7 8	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST RAYMOND S. THURSTON							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10-3-82		2b. HOUR M		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR 9 29 59	6. AGE (IN YEARS LAST BIRTHDAY) YRS. 23	7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	7c. DATE PRONOUNCED DEAD 10-3-82	7d. HOUR 5:40					
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
11. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital S.T.U.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Wine Consulant		12b. KIND OF BUSINESS OR INDUSTRY Super Cut Rite Liquor			
13a. STATE Maryland		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 4812 Eldon Green 21227					
14. FATHER'S NAME FIRST MIDDLE LAST Charles W. Thurston				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Barbara Rae Marks							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 216-76-8124		17. INFORMANT ADDRESS Charles Wm. Thurston 202 Westshire Rd. 21229					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 8880 IMMEDIATE CAUSE (a) Cranio-cerebral injuries DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) on the dam at		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject fell striking head					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) on the dam at		21f. LOCATION CITY OR TOWN STATE Pataspco State Pk. Howard Co., Maryland					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Margaret Meyhall				TITLE (SPECIFY) Assistant				MEDICAL EXAMINER DATE SIGNED 10-4-82			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/6/82		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland			
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.				ADDRESS 4107 Wilkens Ave. 21229				25a. DATE REC'D. BY REGISTRAR OCT 6 1982			
								25b. REGISTRAR'S SIGNATURE John J. Grief			

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ND 1



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR 1. STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 6 2 7 9 REG. NO.			
1. DECEASED NAME (TYPE AND PRINT) Matilda Sophie TIMME				2a. DATE OF DEATH MONTH DAY YEAR 10 16 82				2b. HOUR 12:15 M			
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 03 02		6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Balt.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE ADDRESS) So. Baltimore Genl. Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland				13b. COUNTY Balto. Co.		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2919 Georgia Avenue	
14. FATHER'S NAME FIRST MIDDLE LAST Ferdinand Wedeman				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Wilhelminia Aschenbach							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT 456 Fair Oaks Dr., Severna Park		Mr. Herman F. Timme (SON) 21146			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5070 IMMEDIATE CAUSE (a) Cardio-Respiratory Arrest Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Anoxic Encephalopathy; CVA (c) Aspiration pneumonia PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CHF; Peripheral Vasc. Dis. Upper GI bleed.											
19a. DATE OF OPERATION 10-6-82				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding Diverticulitis				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from saw the deceased alive on 10-16-82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE L. R. Arquillano				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) L. R. Arquillano				22e. ADDRESS S E G H							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 19 OCT '82		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME J. Easter				ADDRESS SINGLETON FUNERAL Home, Glen Burnie, Md.				25a. DATE REC'D. BY REGISTRAR OCT 19 1982			
								25b. REGISTRAR'S SIGNATURE John J. Conner			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 2 8 0

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MYRA		MIDDLE	LAST TOCKER		2a. DATE OF DEATH MONTH DAY YEAR OCT. 31, 1982		2b. HOUR 12:01A	
3. SEX Female		4. RACE Cau.		5. DATE OF BIRTH MONTH DAY YEAR Feb. 14, 1935		6. AGE (IN YEARS LAST BIRTHDAY) 47		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY		MD.		
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY --		
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Delaware		13b. COUNTY New Castle		13c. CITY OR TOWN Wilmington		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3 Wood Road		
14. FATHER'S NAME FIRST MIDDLE LAST Jacob Caplan		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Esther Lafferman								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, IF UNKNOWN) (IF YES, GIVE WAR OR DATES) NO		16b. SOCIAL SECURITY NO. 219-32-7392		17. INFORMANT ADDRESS Edwin Tocker, 3 Wood Rd. Wilm., DE						

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 1830 IMMEDIATE CAUSE (a) <u>terminal ovarian cancer</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) _____ DUE TO, OR AS A CONSEQUENCE OF		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 mo
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>3</u> 19 <u>82</u> , to <u>10/31</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>10/30</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Mark B Frisch mo</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/31/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Mark B Frisch mo		22e. ADDRESS Johns Hopkins Hospital Baltimore Md 21205					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 2, 1982		23c. NAME OF CEMETERY OR CREMATORY Jewish Community		23d. LOCATION CITY OR TOWN COUNTY STATE Wilmington, Delaware N.C., DE	
24. FUNERAL DIRECTOR NAME Alan Schenker		519 Philadelphia Pike Wilmington, Delaware		25a. DATE REC'D. BY REGISTRAR NOV 4 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Signatures should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26281	
1. DECEASED NAME (TYPE OR PRINT) Juanita Toney						2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 10 18 1982		2b. HOUR M			
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 8 20 31	6. AGE (IN YEARS) LAST BIRTHDAY 51 YRS.	IF UNDER 1 YR. MONTHS DAYS 0 0	IF UNDER 24 HRS. HOURS MIN. 0 0	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 22 1982		2d. HOUR 12:15 P.M.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 464 Walton Court				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 464 Walton Court			
14. FATHER'S NAME FIRST MIDDLE LAST Jordan Brown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lelia Hamilton							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 218-42-0202		17. INFORMANT ADDRESS Raymond Toney 1043 Upnore Rd.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on death resulted from <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>Dennis F. Smyth</i>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 10-23-82			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 10/28/82		23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Wm C March F/H 1101 E. North Avenue				25a. DATE REC'D. BY REGISTRAR OCT 27 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>					

RECEIVED
U.S. DEPARTMENT OF THE ARMY
WASHINGTON, D.C. 20315

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NOTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner should not be detached from the body until after the death certificate has been signed by the attending physician and completely filled in by the medical examiner.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 8 2 2 6 2 8 2							
1. DECEASED NAME (TYPE OR PRINT)		Nellie V. Toomey NELLIE		MIDDLE TOOMEY		LAST TOOMEY		2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR	
3. SEX Female		4. RACE Caucasian		5. DATE OF BIRTH MONTH DAY YEAR 4-7-1905		6. AGE (IN YEARS LAST BIRTHDAY) 77 yrs. 77 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS 8. IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Ireland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore County City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY home	
13a. STATE Md.		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 5914 Franklin Avenue 21207	
14. FATHER'S NAME FIRST MIDDLE LAST Patrick Vahey				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bridgette Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 222-20-2703		17. FUNERAL HOME ADDRESS Doherty-Wickersham Funeral Home 19806 1900 Delaware Ave., Wilmington, Del.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1579 RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CARCINOMA OF PANCREAS DUE TO, OR AS A CONSEQUENCE OF (c)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 9									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Leonard E. Bienkowski				DEGREE M.D.				22c. DATE SIGNED 10/10/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LEONARD E. BIENKOWSKI M.D.				22e. ADDRESS ST. AGNES HOSPITAL, BALT. MD.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-13-82		23c. NAME OF CEMETERY OR CREMATORY St. Joseph on the Brandywine Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE New Castle, Delaware			
24. FUNERAL DIRECTOR NAME Schimunek Funeral Home, Inc. 3331 Brehms Lane, Baltimore, Md. 21213				25a. DATE RECEIVED BY REGISTRAR OR REGISTRAR'S SIGNATURE OCT 13 1982 John J. Canard					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page should be detached for use as the burial transit permit. Then please remove carbon paper. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 2 8 3

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		MONTH DAY YEAR		2b. HOUR	
FIRST MIDDLE LAST		10 31 82		5:15 PM	
Frances Topa					
1. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)	7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	Caucasian	Aug 21 1915	67	Baltimore City, MD	
8. BIRTH PLACE (STATE OR FOREIGN COUNTRY)	9. CITIZEN OF WHAT COUNTRY?	10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
Nd	U.S.A.				
11. CITY OR TOWN OF DEATH	12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	13. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Baltimore	Johns Hopkins Hospital	Homemaker			
14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)	15. CITY OR TOWN	16. INSIDE CITY LIMITS?	17. STREET ADDRESS		
Nd	Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	2533 Foster Ave		
18. FATHER'S NAME	19. MOTHER'S MAIDEN NAME				
Leon	Elizabeth				
20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	21. SOCIAL SECURITY NO.	22. INFORMANT	ADDRESS		
No	214-03-2451	Janet Rasinski	911 Sibley Rd		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
1579 Respiratory failure					4 days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
(b) Pleural Effusions					7 days
(c) metastatic pancreatic carcinoma					5 months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
Renal failure Anasarca					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?		
6-18-82	Pancreatic Carcinoma	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
	P.M. 19				
21d. INJURY OCCURRED	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/22, 19 82, to 10/31, 19 82, that (I) (we) last saw the deceased alive on 10/30, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE		DEGREE		22c. DATE SIGNED	
David W. Crist MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		10/31/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
David W. Crist		Johns Hopkins Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN	COUNTY	STATE
Burial	11-4-82	St. Stanislaus	Baltimore	Nd	
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Raymond Kozlowski		NOV 3 1982		John J. Comer	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The funeral director should remove carbon papers, pages 1 and 2 and should be filed within 72 hours after death with the State Department of Health and Mental Hygiene prior to removal for burial, cremation or other disposition.

IMPORTANT: If item 21 is marked of item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 2 8 4

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) THOMAS D. TORTORO			2a. DATE OF DEATH MONTH DAY YEAR OCT. 19, 1982		2b. HOUR MIN. 10:45 P M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR June 14, 1960		6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student		12b. KIND OF BUSINESS OR INDUSTRY College	
13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)									
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5622 Laurelton Ave. 21214	
14. FATHER'S NAME FIRST MIDDLE LAST Russell R. Tortoro				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phyllis D. Kummer					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 212-80-3322		17. INFORMANT ADDRESS Phyllis D. Tortoro, 5622 Laurelton Av. 21214					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) hypoxia and hypercarbia and hypertension DUE TO, OR AS A CONSEQUENCE OF (c) pneumonia and leukemia APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) acute lymphocytic leukemia									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 10/18 19 82 , to 10/19 19 82 , that (I) (we) last saw the deceased alive on 10/19 19 82 , and that (in (my) (our) opinion) death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Robert I. Garver, Jr.				DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10/19/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT I. GARVER, JR.				22e. ADDRESS JOHNS HOPKINS HOSP BALTIMORE, MD					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Oct. 23, 1982		23c. NAME OF CEMETERY OR CREMATORY Westview		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville, Balto., Md.			
24. FUNERAL DIRECTOR NAME ADDRESS ROBERT C. ALTENBURG FUNERAL HOME, INC. 6009 Harford Rd., Balto., Md. 21214				25a. DATE REC'D. BY REGISTRAR OCT 22 1982		25b. REGISTRAR'S SIGNATURE John J. Conner			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal with the State Dept. of Health and Mental Hygiene. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 2 8 5

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
FIRST MIDDLE LAST Dorothy Totis			MONTH DAY YEAR October 30, 1982			HOURS MIN. 3:50 PM		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.		
female	white	MONTH DAY YEAR Aug. 2, 1928	54 YRS.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>						
Maryland	U.S.A.	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore	Maryland General Hospital			Homemaker				
13a. STATE		13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		
Maryland		City	Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		3459 Hickory Ave. 21211		
14. FATHER'S NAME FIRST MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST					
Louis John Sisselberger			Geneva Unknown					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No			214-24-9846		25 Lower Gate Ct. Mr. Victor Totis Owings Mills, Md. 21117			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Arrest								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.								
(b) Carcinoma of the Lung with Metastatic of the Brain DUE TO, OR AS A CONSEQUENCE OF								
(c) Stroke Left Side Hemiparesis/ Congested Heart Failure DUE TO, OR AS A CONSEQUENCE OF								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
					YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (this hospital) attended the deceased from September 2, 1982 , to October 30, 1982 , that (we) last saw the deceased alive on October 30, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) did (did not) view the body after death.								
22b. SIGNATURE Parminderjeet Sandhu						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/30/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Parminderjeet Sandhu, M.D.				22e. ADDRESS c/o Maryland General Hospital				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial		11/1/82		Druid Ridge CEMETERY		Pikesville Balto. MD		
24. FUNERAL DIRECTOR Loring Byers Funeral Directors NAME ADDRESS 8728 Liberty Rd. Randallstown, Md. 21133						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John J. Carver
						NOV 1 1982		

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 2 8 6

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST Annie		MIDDLE		LAST Travis		2a. DATE OF DEATH		MONTH 10		DAY 16		YEAR 82		2b. HOUR 4:45 P.M.	
3. SEX Female		4. RACE Black		5. DATE OF BIRTH		MONTH 10		DAY 21		YEAR 94		6. AGE (IN YEARS LAST BIRTHDAY)		87 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.											
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Good Samaritan Hospital												12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 808 Reverdy Rd.									
14. FATHER'S NAME FIRST Alexander				MIDDLE		LAST Bazzle		15. MOTHER'S MAIDEN NAME FIRST Ida				MIDDLE Waters				LAST	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 217-22-9618		17. INFORMANT ADDRESS Thelma Martin 808 Reverdy Erd, 21212													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Dissecting aortic aneurysm</u> 4410 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____																	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from <u>10-16-</u> 19 <u>82</u> , to <u>10-16-</u> 19 <u>82</u> that (I) (we) last saw the deceased alive on <u>10-16-</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																	
22b. SIGNATURE ADEL S. EL-HENNAWY				DEGREE M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10-16-82									
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ADEL S. EL-HENNAWY				22e. ADDRESS GSH.													
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 10/21/82		23c. NAME OF CEMETERY OR CREMATORY Mount Calvary Cem				23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co Md.							
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue				ADDRESS 15a. DATE REC'D. BY REGISTRAR OCT 18 1982				REGISTRAR'S SIGNATURE John J. Canfield									

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

POST OFFICE

CHIEF OF POST



ITEMS #18a-22a Film G575 1/11/83 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 26287

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		XX MONTH DAY YEAR		2b. HOUR	
PAMELA		Anne		TRENT				10-17-82		19		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	White	9-24-57		25 YRS.						10-17-82		11:10A	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH					
Balto. Md.		U.S.A.		WIDOWED		DIVORCED		Baltimore City					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION		12b. KIND OF BUSINESS OR INDUSTRY							
Baltimore		410 W. Franklin Street Apt 10-D		Social Services Dept. Balto.									
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Md.						Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		410 W. Franklin St. - 21201		City	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME									
Paul T. Trent				Ruth C. Kraft									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS					
No				215-66-0900		Mr. Paul T. Trent		618 E. 33rd St. 21218					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) Desipramine Intoxication													
9503													
DUE TO, OR AS A CONSEQUENCE OF													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?					
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED					
				? P.M. 10/?/82				self/ingested					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY				21f. LOCATION					
				Home				410 W. Franklin St. Baltimore Md.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from:													
Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE				TITLE (SPECIFY)				DATE SIGNED					
Margarita A. Korell, M.D.				Assistant				10-18-82					
EXAMINER'S NAME				ADDRESS									
(TYPE OR PRINT)				111 Penn Street									
23a. BURIAL, CREMATION, REMOVAL				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION					
Burial				10-21-82		Holly Hill Cem.		Middle River, Md.					
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
John C. Miller Inc				6415 Belair Rd. - 21206				OCT 19 1982					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 1. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

1701 BP 318

RECEIVED
U.S. DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D.C. 20535

DATE

TO

FROM

SUBJECT

REFERENCE

REMARKS

INITIALS

DATE

TIME

BY

REMARKS

INITIALS

DATE

TIME



DATE

TIME

BY

INITIALS

DATE



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26288	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ALBERT TREPOLSKY							2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10-24-82		2b. HOUR M 8:53P		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR DEC. 25, 1895		6. AGE (IN YEARS) LAST BIRTHDAY YRS 86		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10-24-82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) RUSSIA			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		
11. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4010 Woodmere Avenue					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SALESMAN		12b. KIND OF BUSINESS OR INDUSTRY RETAIL	
13a. STATE MARYLAND			13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4010 WOODMERE AVE. #21215		
14. FATHER'S NAME FIRST MIDDLE LAST FRANK TREPOLSKY						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SOPHIE UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) YES			(IF YES, GIVE WAR OR DATES) WWI Army			16b. SOCIAL SECURITY NO. 215-07-6282			17. INFORMANT MRS. IDA TREPOLSKY 4010 WOODMERE AVE. BALTO., MD 21215		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Margarita A. Korell</i>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 10-25-82			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE OCT. 26, 1982		23c. NAME OF CEMETERY OR CREMATORY AITZ CHAIM			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND		
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. 6010 REISTERSTOWN RD. BALTO., MD 21215						25a. DATE REC'D. BY REGISTRAR OCT 27 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Canfield</i>			

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION
WASHINGTON, D. C. 20535

RECEIVED

NOV 19 1964

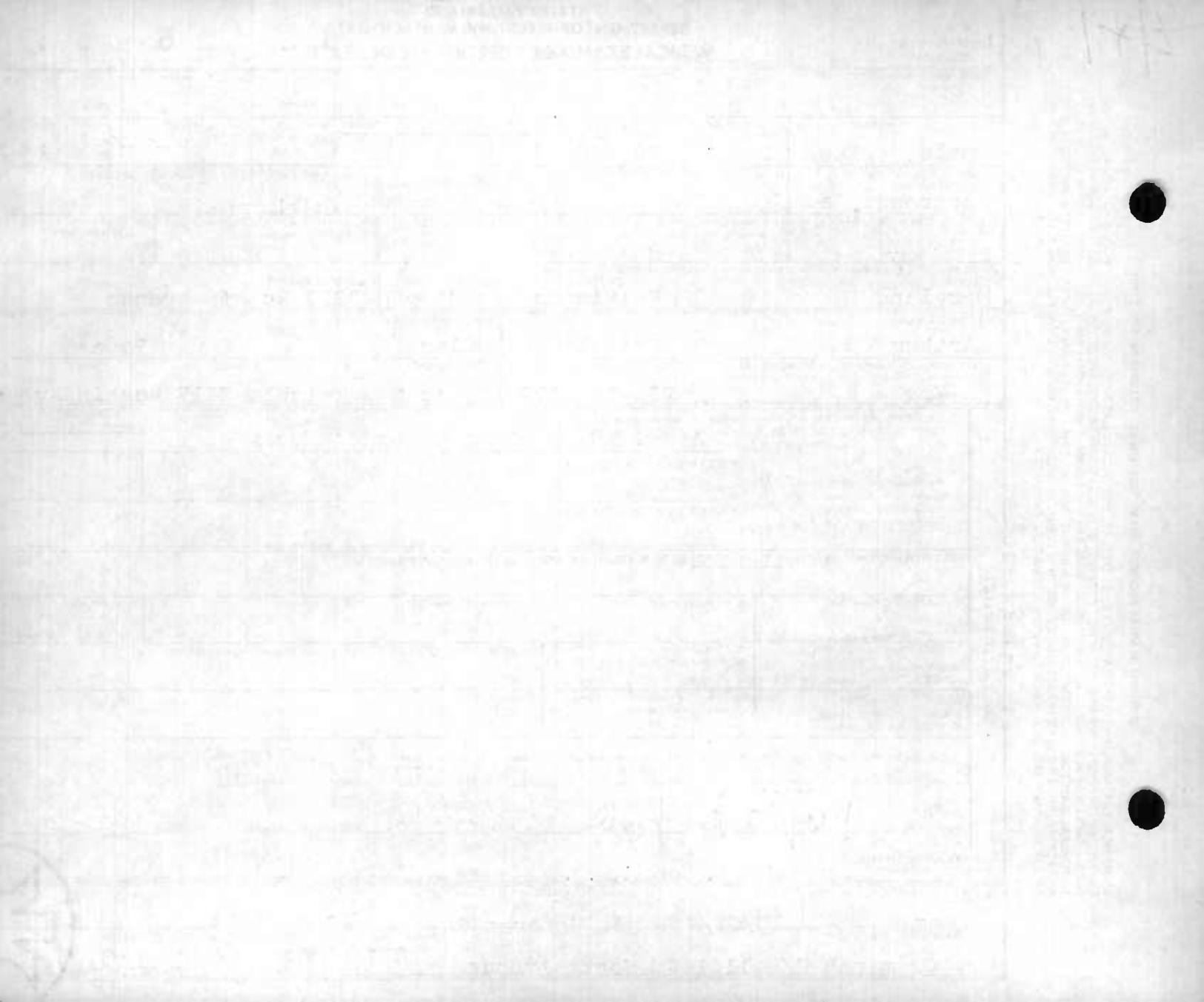


1304 BP _____
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

FOR 1- STATE REGISTRAR		DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH				REG. NO. 2 6 2 8 9	
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST		2a. DATE KNOWN OF DEATH	
ARTHUR J. TRIMBLE						MONTH DAY YEAR	
3. SEX				4. RACE		2b. DATE OF ESTI- MATED	
male				Black		10-24-82	
5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		7c. DATE PRONOUNCED DEAD	
MONTH DAY YEAR		LAST BIRTHDAY		MONTHS DAYS HOURS MIN.		MONTH DAY YEAR	
2 4 20		62 RS.				10-24-82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
Norcross, Ga.		USA				Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
Baltimore		2217 Ruskin Avenue					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
Arthur Trimble				Clara Boyce			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
Yes		238-14-2197		Essie Mae Trimble 2217 Ruskin Avenue			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?	
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		TITLE (SPECIFY)				DATE SIGNED	
		M.D. Assistant				10-25-82	
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS					
Margarita A. Korell, M.D.		111 Penn Street					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		10/29/82		Md. Veteran Com		Crownsville Md.	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Wm. C. March F/H		1101 E. North Avenue		OCT 29 1982			



STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2

2 6 2 9 0

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MARY MIDDLE TRUFFER LAST			2a. DATE OF DEATH MONTH DAY YEAR 10 - 12 - 82			2b. HOUR 15 P M					
3. SEX Female		4. RACE White		5. AGE (IN YEARS LAST BIRTHDAY) 7, 130/02		6. AGE (IN YEARS LAST BIRTHDAY) 82 80 YRS		7. IF UNDER 1 YEAR MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.	
8. BIRTHPLACE (STATE OR FOREIGN) Maryland		9. CITIZEN OF WHAT COUNTRY? U.S.A.		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
12. OR TOWN OF DEATH Baltimore		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Greater Penn. Ave Nursing Center				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker				15. KIND OF BUSINESS OR INDUSTRY Home	
16a. RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 12a. STATE Md		16b. COUNTY Baltimore		16c. CITY OR TOWN Baltimore		17. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		18. STREET ADDRESS 4126 Raymond Ave			
19. FATHER'S NAME FIRST MIDDLE LAST Unknown				20. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unknown							
21a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		21b. SOCIAL SECURITY NO. 220-07-1741		22. INFORMANT Andrew Truffer				23. ADDRESS 402 S. Montford Ave			
24. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Diabetes Mellitus 2500 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Hypertension											
25a. DATE OF OPERATION 9-9		25b. CONDITION FOR WHICH OPERATION WAS PERFORMED				26a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		26b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
27a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		27b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		27c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
28a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		28b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		28c. LOCATION STREET CITY OR TOWN COUNTY STATE							
29. I certify that (I) (this hospital) attended the deceased from 6-14, 19 82, to 10-12, 19 82, that (I) (we) last saw the deceased alive on 10-12, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
30. SIGNATURE R. D. Crostey				31. DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				32. DATE SIGNED			
33. PHYSICIAN'S NAME (TYPE OR PRINT) R. D. Crostey MD				34. ADDRESS 1235 E. Monument St Balto Md							
35. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		36. DATE 10-15-82		37. NAME OF CEMETERY OR CREMATORY Eastview Cem		38. LOCATION Baltimore City, Md. STATE					
39. FUNERAL DIRECTOR Raymond Kaczynski				40. ADDRESS 2520 Ash St.				41. DATE REC'D. BY REGISTRAR 10 OCT 13 1982			



~~_____~~

Item #8 Film G574 12/20/82 rc

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 8 2 2 6 2 9 1

1. DECEASED NAME (TYPE OR PRINT) ELVIN TRUSTY			2a. DATE OF DEATH MONTH DAY YEAR OCT. 5, 1982		2b. HOUR MIN 12:26 M
3. SEX male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 7 8 19		6. AGE (IN YEARS LAST BIRTHDAY) 63 YRS	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST - = -			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST - - -		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 219-07-2861		17. INFORMANT ADDRESS Mary Trusty 1100 E. Biddle St.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Superior vena cava obstruction 1509 DUE TO, OR AS A CONSEQUENCE OF (b) Adenocarcinoma of the Esophagus DUE TO, OR AS A CONSEQUENCE OF (c) the lungs Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH ~10 hrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION 9/8/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Esophageal cancer		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/2 , 19 82 , to 10/5 , 19 82 , that (I) (we) lost saw the deceased alive on 10/5 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Vincent K. H. Tam, MD				22c. DATE SIGNED 10/5/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Vincent K. H. Tam				22e. ADDRESS Johns Hopkins Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/9/82		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem.	
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Avenue			
25a. DATE REC'D. BY REGISTRAR OCT 6 1982		25b. REGISTRAR'S SIGNATURE John J. Connelley			

THE FOLLOWING INFORMATION IS CONTAINED IN THE ABOVE MENTIONED DOCUMENTS:

1. [Illegible text]

2. [Illegible text]

3. [Illegible text]

4. [Illegible text]

5. [Illegible text]

6. [Illegible text]

7. [Illegible text]

8. [Illegible text]

9. [Illegible text]

10. [Illegible text]

11. [Illegible text]

12. [Illegible text]

13. [Illegible text]

14. [Illegible text]

15. [Illegible text]

16. [Illegible text]

17. [Illegible text]

18. [Illegible text]

19. [Illegible text]

20. [Illegible text]

21. [Illegible text]

22. [Illegible text]

23. [Illegible text]

24. [Illegible text]

25. [Illegible text]

26. [Illegible text]

27. [Illegible text]

28. [Illegible text]

29. [Illegible text]

30. [Illegible text]

31. [Illegible text]

32. [Illegible text]

33. [Illegible text]

34. [Illegible text]

35. [Illegible text]

36. [Illegible text]

37. [Illegible text]

38. [Illegible text]

39. [Illegible text]

40. [Illegible text]

41. [Illegible text]

42. [Illegible text]

43. [Illegible text]

44. [Illegible text]

45. [Illegible text]

46. [Illegible text]

47. [Illegible text]

48. [Illegible text]

49. [Illegible text]

50. [Illegible text]

51. [Illegible text]

52. [Illegible text]

53. [Illegible text]

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81. [Illegible text]

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83. [Illegible text]

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89. [Illegible text]

90. [Illegible text]

91. [Illegible text]

92. [Illegible text]

93. [Illegible text]

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97. [Illegible text]

98. [Illegible text]

99. [Illegible text]

100. [Illegible text]

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 2 9 2

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST HENRY	MIDDLE	LAST TUCKER	2a. DATE OF DEATH MONTH DAY YEAR 10 14 1982		2b. HOUR 10:30 AM		
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR MAR. 20, 1914		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 74 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.			
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) NORTH CHARLES GEN. HOSP.			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) FUR BUYER		12b. KIND OF BUSINESS OR INDUSTRY DEPT. STORE		
13a. STATE MARYLAND		13b. COUNTY BALTO.		13c. CITY OR TOWN TOWSON		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 8415 BELLONA LA., APT. 310	
14. FATHER'S NAME FIRST MIDDLE LAST NATHAN ISAAC TUCKER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CELIA UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 233-09-5875		17. INFORMANT ADDRESS MRS. HELEN SARA TUCKER 8415 BELLONA LA., APT. 310		17a. DATE #21204			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Acute MYOCARDIAL INFARCTION - DUE TO, OR AS A CONSEQUENCE OF (b) AND Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last } DUE TO, OR AS A CONSEQUENCE OF (c) TO DAY.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH DAYS.
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 09/27/1982 to 10/14/1982, that (I) (we) lost saw the deceased alive on 10/14/1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE J. R. Archer MD				DEGREE M.D.		22c. DATE SIGNED 10/14/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) ANJARIA				22e. ADDRESS NORTH CHARLES GEN HOSPITAL BALTIMORE, MD. 21218					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 15, 1982		23c. NAME OF CEMETERY OR CREMATORY BETH TFILOH		23d. LOCATION BALTIMORE		23e. COUNTY STATE MARYLAND	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD., BALTO., MD 21215				25a. DATE REC'D. BY REGISTRAR OCT 20 1982		25b. REGISTRAR'S SIGNATURE John J. Connel			

MEDICAL CERTIFICATION

1. The Commission of the General Land Office is composed of the following members:

2. The Commission is to be presided over by the Secretary of the Interior.

3. The Commission is to be composed of the following members:

4. The Commission is to be composed of the following members:

5. The Commission is to be composed of the following members:

6. The Commission is to be composed of the following members:

7. The Commission is to be composed of the following members:

8. The Commission is to be composed of the following members:

9. The Commission is to be composed of the following members:

10. The Commission is to be composed of the following members:

11. The Commission is to be composed of the following members:

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as left, 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 2 9 3

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH				MONTH		DAY		YEAR		2b. HOUR	
Thelma E. Tucker								10				7		82				M	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS									
Female		Black		MONTH 3 DAY 30 YEAR 07		75 YRS.		MONTHS		DAYS		HOURS		MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH													
Ga.		USA				Baltimore City,												MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY													
Baltimore		4005 Edmondson Avenue																	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS											
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		4005 Edmondson Ave											
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
FIRST MIDDLE LAST		FIRST MIDDLE LAST																	
John Glass		Vollie White Glass																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
No		219-20-5301		Artemas Tucker		13 BeachHill Dr. N.J.													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART I. DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF (b)		DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
4029		Cardiac Arrhythmia				Hypertensive Cardiovascular Disease													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.																			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?													
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>													
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)															
		HOUR A.M. MONTH DAY YEAR																	
		P.M. 19																	
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION															
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		(AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET		CITY OR TOWN		COUNTY		STATE									
22a. I certify that (I) (this hospital) attended the deceased from		1-28-1975		to		8-10-1982		that (I) (we) lost											
saw the deceased alive on		8-10-1982		and that in (my) (our) opinion death occurred on the date and hour and from the causes stated															
above, (I) (we) (did) (did not) view the body after death.																			
22b. SIGNATURE		DEGREE		22c. DATE SIGNED															
Percival C. Smith		M.D.		10-12-82															
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS																	
Percival C. Smith		4200 Edmondson Ave		21229															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		CITY OR TOWN		COUNTY		STATE							
BURIAL		10/ 13/82		Cedar Hill Cem		Baltimore												Md.	
24. FUNERAL DIRECTOR		NAME		ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE											
Wm. C. March F/ H 1101 E. North Avenue						OCT 13 1982		John J. Lohr											

2

CHICAGO

100-100000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

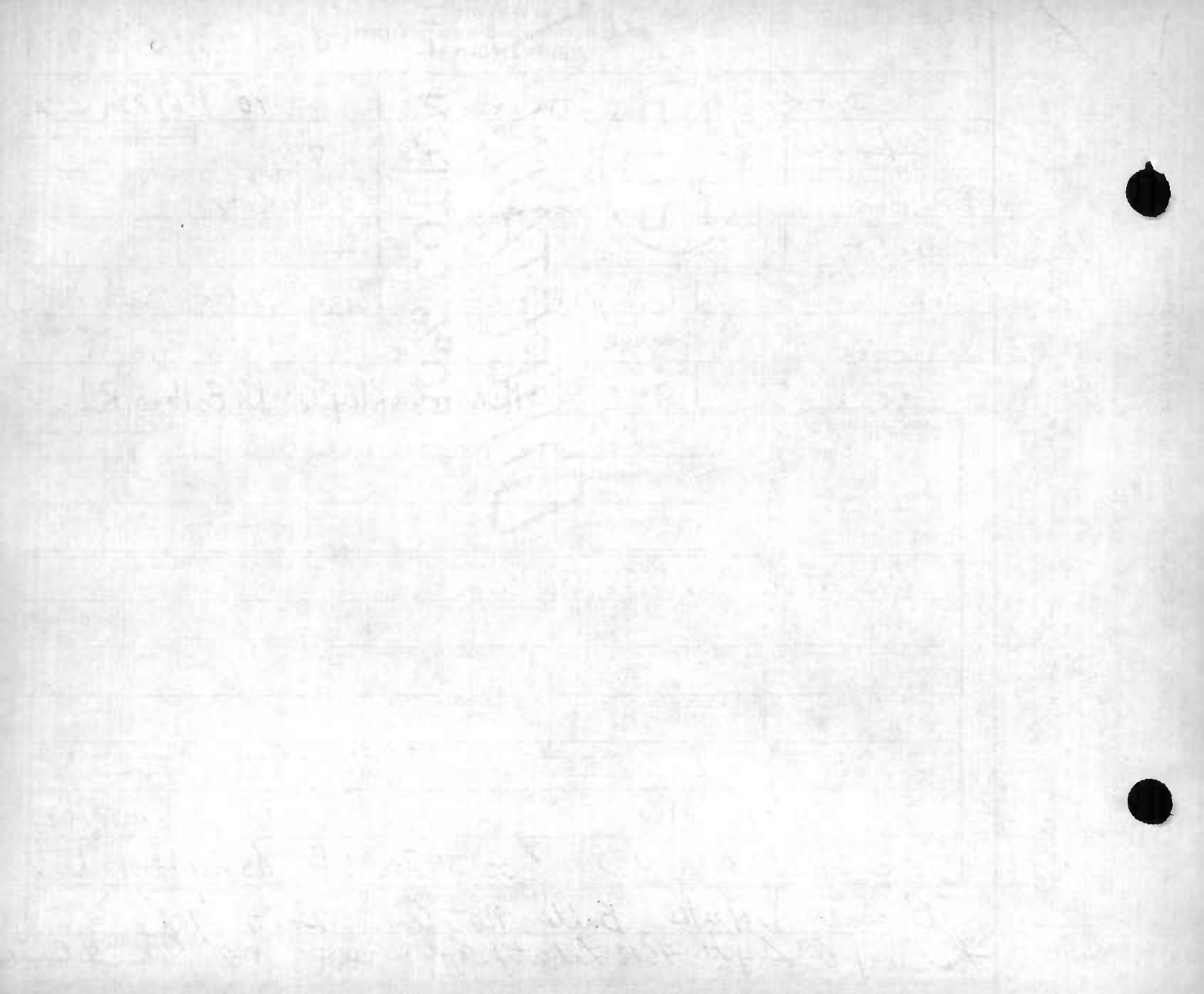
item 11 #G572 10/20/82 ph

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

1- STATE REGISTRAR

REG. NO. 8 2 2 6 2 9 4

1. DECEASED NAME (TYPE OR PRINT) Dorothy Tuckson			2a. DATE OF DEATH MONTH 10 DAY 16 YEAR 1982			2b. HOUR 6¹⁰ A.M.					
3. SEX Female		4. RACE B		5. DATE OF BIRTH MONTH 12 DAY 6 YEAR 1908		6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS.		IF UNDER 1 YEAR MONTHS DAYS 		IF UNDER 24 HRS. HOURS MIN. 	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto City MD.					
10. CITY OR TOWN OF DEATH Balto City		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mercy Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 		12b. KIND OF BUSINESS OR INDUSTRY 			
13a. STATE MD			13b. COUNTY 		13c. CITY OR TOWN City, Balto		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 339 E 27th St. Balto. MD		
14. FATHER'S NAME FIRST Louis MIDDLE LAST White			15. MOTHER'S MAIDEN NAME FIRST Louise MIDDLE LAST Smith			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no					
16b. SOCIAL SECURITY NO. 215 12 3623			17. INFORMANT ADDRESS Marion Oakley Quaker Bottom Rd.								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrhythmia 4254 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) (c) DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Congestive Cardiomyopathy											
19a. DATE OF OPERATION 10/3			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) 					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 			21f. LOCATION STREET CITY OR TOWN COUNTY STATE 					
22a. I certify that (I) this hospital attended the deceased from 10/3 , 19 82 , to 10/6 , 19 82 , that (I) (we) last saw the deceased alive on 10/6 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death.											
22b. SIGNATURE G Grolcan MD						DEGREE 			22c. DATE SIGNED 10/6/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) G GROLCAN MD						22e. ADDRESS 301 St. Paul St. Mercy Hospital					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/12/82			23c. NAME OF CEMETERY OR CREMATORY Balto. Nat. Am.			23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Ind.		
24. FUNERAL DIRECTOR NAME Leroy D. Dytt ADDRESS 4600 Liberty St. Balto.						DATE REC'D. BY REGISTRAR OCT 8 1982			REGISTRAR'S SIGNATURE John J. Conner		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 2 9 5 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) JOSEPHINE TUNSTALL						2a. DATE OF DEATH MONTH DAY YEAR 10/10/82		2b. HOUR 3:15 P.M.			
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 12 23 19		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN) North Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hosp				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Abusewife		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13a. STATE MD		13b. COUNTY -			
13c. CITY OR TOWN Baltimore						13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1533 N. Patterson			
14. FATHER'S NAME FIRST MIDDLE LAST NOAH HORTON						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADELINE ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO						16b. SOCIAL SECURITY NO. 214-18-1250		17. INFORMANT Edith Jones			
						ADDRESS 1533 N. Patterson Ave					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1991 IMMEDIATE CAUSE (a) Sepsis DUE TO, OR AS A CONSEQUENCE OF (b) Adeno carcinoma, DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Acute Renal Failure											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE David Matchar MD						DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/10/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID MATCHAR						22e. ADDRESS Lutheran Hosp. Balto MD 21216					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10-14-82		23c. NAME OF CEMETERY OR CREMATORY CEDAR Hill Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel County, Md.			
24. FUNERAL DIRECTOR NAME Calvin B. Scruggs						ADDRESS 1412 E. Preston St.		25a. DATE REC'D. BY REGISTRAR OCT 13 1982		25b. REGISTRAR'S SIGNATURE Joan J. Carver	

Items #10a-22a Film G575 1/10/82 STATE OF MARYLAND
 FOR
 1- STATE REGISTRAR
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

2 2 6 2 9 6

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> MONTH		DAY		YEAR		2b. HOUR							
Michael G. Tunstall (Tunstall)								DATE ESTIMATED		<input type="checkbox"/> 10		12		1982		M							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR		2d. HOUR			
male		Black		1 13 49		33 YRS.		MONTHS		DAYS		HOURS		MIN.		10		12		1982		M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH															
Maryland		USA						Baltimore City,															
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY																	
Baltimore		Mercy Hospital																					
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS															
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		600 Whitelock St. Apt 3B															
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																					
George M. Tunstall		Margaret Woodland																					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS																	
No		N/A																					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		PART 1 DEATH WAS CAUSED BY:		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
3049		IMMEDIATE CAUSE (a) Narcotism																					
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last		(b)																					
		(c)																					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1																							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE																			
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion		death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED		10/13/82																	
EXAMINER'S NAME (TYPE OR PRINT)		Thomas D. Smith, M.D.		ADDRESS		111 Penn St. Balto., MD.																	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE																	
BURIAL		10/18/82		Arbutus Mem. Pk		Arbutus Md																	
24. FUNERAL DIRECTOR NAME		ADDRESS		25a. DATE RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE																	
Wm/ C. March F/H		1101 E. North Avenue				OCT 18 1982																	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

SECRET

1-1-1

1-1-1

SECRET



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH - 16-50M 4/82
(VRA 15.4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 2 9 7

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) BABY BOY TURNER			2a. DATE OF DEATH MONTH DAY YEAR 10-26-82			2b. HOUR 1:50 A M	
3. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 10 24 82		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 2	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S. A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN THIS FACILITY, GIVE STREET ADDRESS) UNIVERSITY OF MARYLAND HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) N/A	
13a. STATE MARYLAND		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES W TURNER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST REBECCA E WOODING		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. NONE	
17. INFORMANT MEDICAL RECORD		18. ADDRESS 755 W LEXINGTON ST		19. STREET ADDRESS 755 W LEXINGTON ST		20. STREET ADDRESS	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 7651		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) Prematurity			
DUE TO, OR AS A CONSEQUENCE OF (b) POSSIBLE INTRAVENTRICULAR HEMORRHAGE			
DUE TO, OR AS A CONSEQUENCE OF (c)			

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) HYALINE MEMBRANE DISEASE			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from OCTOBER 24, 19 82 , to OCTOBER 26, 19 82 , that (I) (we) last saw the deceased alive on OCTOBER 26, 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE D Parker MD		22c. DATE SIGNED OCTOBER 26, 1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D Parker MD		22e. ADDRESS UNIV. OF MARYLAND HOSPITAL 22 S. GREENE ST.	

23a. BURIAL, CREMATION, REMOVAL (STATE) Removal		23b. DATE 11/4/82		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR NOV 9 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	

1. The purpose of this document is to provide information regarding the activities of the [redacted] in the [redacted] area. This information is being provided for your information and is not to be distributed outside your agency.

2. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

3. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

4. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

5. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

6. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

7. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

8. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

9. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.

10. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area. The [redacted] has been identified as a [redacted] and is currently active in the [redacted] area.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 2 9 8

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Barbara (nmn) Turner			2a. DATE OF DEATH MONTH DAY YEAR 10/29/82		2b. HOUR 3:06 A.M.		
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3/24/08		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) unknown		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hosp. 130 Ashburton St		12a. USUAL OCCUPATION (TYPE OR WORKING LIFE) Housewife Retired		12b. KIND OF BUSINESS OR INDUSTRY --	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)							
13a. STATE Md.		13b. COUNTY --		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1339 W. Mosher St							
14. FATHER'S NAME FIRST MIDDLE LAST Grover Barnes				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Waters			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 21624-3104		17. INFORMANT ADDRESS Mrs. Katherine V. Bray, 1610 Joppa, Md. 21085 Mandeville Road			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)

PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) **Cardiopulmonary arrest.****4960**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Chronic Obstructive Pulmonary Disease**

DUE TO, OR AS A CONSEQUENCE OF

(c) **Bronchopneumonia**

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):

Congestive heart failure

MEDICAL CERTIFICATION

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Oct. 4 , 19 82 , to Oct. 29 , 19 82 , that (I) (we) lost saw the deceased alive on Oct. 29 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE CH-CH		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/29/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) CHENG CHUNG LIN		22e. ADDRESS Lutheran Medical Center 730 Ashburton St. Baltimore MD					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 1, 1982		23c. NAME OF CEMETERY OR CREMATORY Community Baptist Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Joppa Harford Md.	
24. FUNERAL DIRECTOR NAME Howard K. McComas III, Abingdon, Md. 21009				25a. DATE REC'D. BY REGISTRAR NOV 1 1982			
25b. REGISTRAR'S SIGNATURE John J. Smith							

PERIODICALLY

Handwritten notes and signatures, including "C. C. C.", "C. C. C.", and "C. C. C.", along with various illegible scribbles and marks.

5

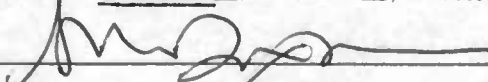
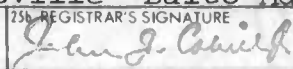
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

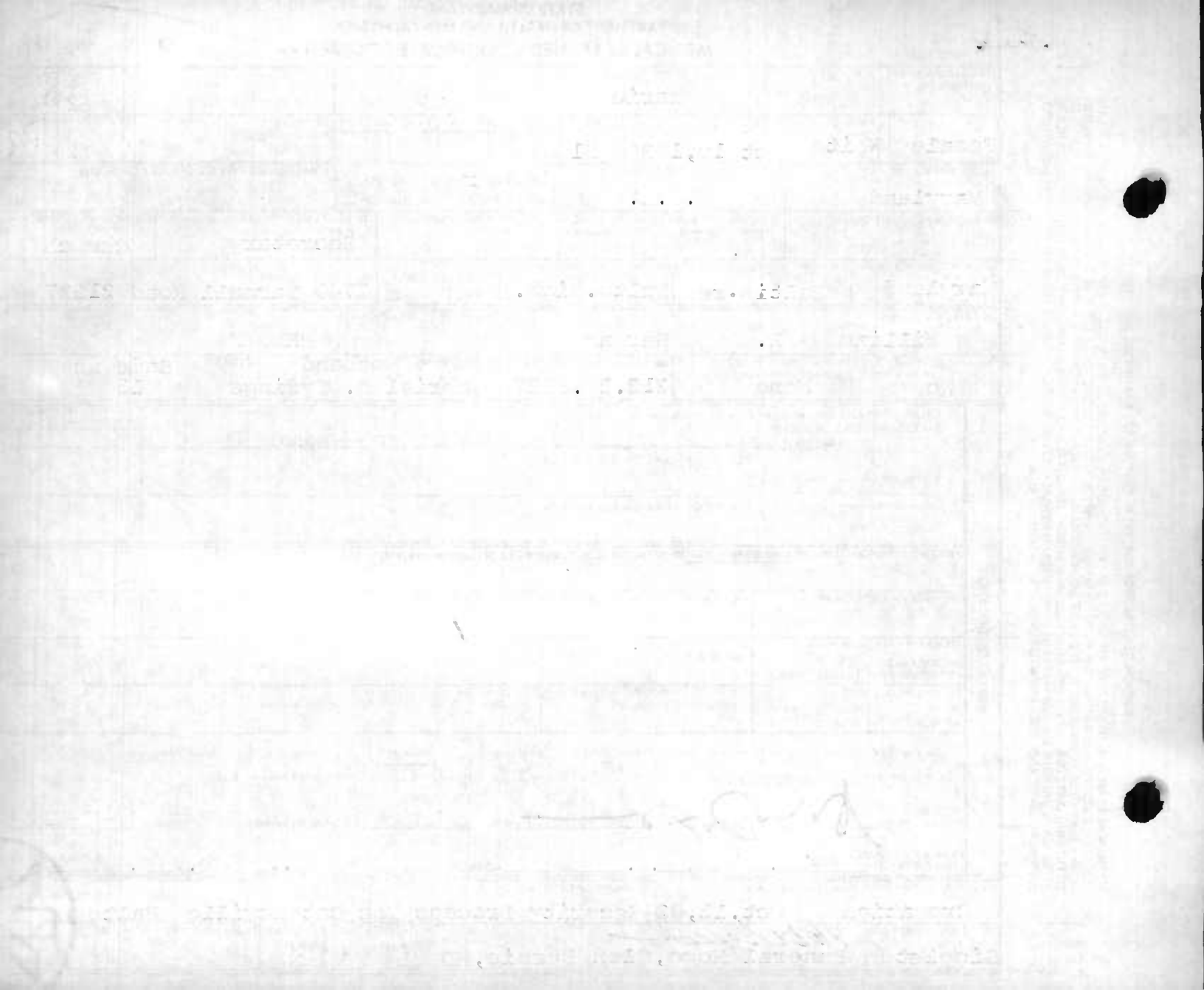
8 2 2 6 2 9 9

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) NEALY		FIRST MIDDLE LAST TURNER		20. DATE OF DEATH MONTH DAY YEAR 10/8/82		2b. HOUR 11:25 PM	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 02 24 31		6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) So. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) BON SECOURS		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unknown		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Canty		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary McGriff		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 248-48-2107	
17. INFORMANT Margaret Harrison		ADDRESS 3347 Woodland Ave		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY VASCULAR ACCIDENT 4360 DUE TO, OR AS A CONSEQUENCE OF (b) HYPERTENSION, CIGARETTES DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 7 1/2 days			
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a) _____							
19a. DATE OF OPERATION -		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED -		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) -		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. - 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) -			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK -		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) -		21f. LOCATION STREET CITY OR TOWN COUNTY STATE -			
22a. I certify that (I) (this hospital) attended the deceased from September 29 1982 , to October 8 1982 , that (I) (we) last saw the deceased alive on October 7 1982 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Bruce Kohn		DEGREE M.D.		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-8-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BRUCE KOHN		22e. ADDRESS 2000 W. BALTIMORE ST., BALTIMORE, MD 21223					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/13/82		23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Avenue		25. DATE REC'D. BY REGISTRAR OCT 11 1982 REGISTRAR'S SIGNATURE John J. Connel					

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26300	
1. DECEASED NAME (TYPE OR PRINT) ANN Marie TYDINGS						2a. DATE KNOWN OF DEATH 10 9 19 82		2b. HOUR 9:47 a.m.			
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Oct 19, 1930	6. AGE (IN YEARS LAST BIRTHDAY) 51 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD 10 9 19 82		2d. HOUR 9:47 a.m.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Secretary		12b. KIND OF BUSINESS OR INDUSTRY Church			
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Balto. High.		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2749 Yarnall Road 21227			
14. FATHER'S NAME FIRST MIDDLE LAST William K. Harman						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) None		17. INFORMANT Husband		17. ADDRESS Same as		17. ADDRESS 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4029 IMMEDIATE CAUSE (a) Hypertensive cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 a											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 		TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER		DATE SIGNED 10-10-82			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.		ADDRESS 111 Penn St., Balto., Md. 21201									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE Oct. 12, 82		23c. NAME OF CEMETERY OR CREMATORY Security Process Inc		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto Md					
24. FUNERAL DIRECTOR NAME Singleton Funeral Home, Glen Burnie, MD		25a. DATE REC'D. BY REGISTRAR OCT 11 1982		25b. REGISTRAR'S SIGNATURE 							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 0 1

FOR
1. STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edna Eudora Tyler			2a. DATE OF DEATH MONTH DAY YEAR 10 11 1982		2b. HOUR M
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Aug. 29, 1892		6. AGE (IN YEARS LAST BIRTHDAY) 90 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Hoopersville, Md.	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 4508-D Old Frederick Road		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Henry W. Ruark			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Clara Louisa Tyler		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) - - - - - 214 78 3216	17. INFORMANT ADDRESS Harriet Schaffer Hampstead, Md.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Cardiac Arrest</u> 4029 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertensive Arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Cardiovascular Disease</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>Immediate</u> <u>Unknown</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) <u>did not</u> attend the deceased from <u>3/31</u> , 19 <u>61</u> , to <u>10/11</u> , 19 <u>82</u> , that (I) <input checked="" type="checkbox"/> lost saw the deceased alive on <u>8/4</u> , 19 <u>82</u> , and that in (my) <u>own</u> opinion death occurred on the date and hour and from the causes stated above, (I) <u>did not</u> view the body after death.					
22b. SIGNATURE <u>C. W. Ratliff, Jr.</u>		DEGREE <u>M.D.</u>		22c. DATE SIGNED 10/11/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Cliff Ratliff, Jr., M.D.		22e. ADDRESS 5772 Westview Mall Baltimore, Maryland 21228			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/14/82	23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION Baltimore, Md.	
24. FUNERAL DIRECTOR MITCHELL-WIEDEFELD HOME, INC.		ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR OCT 15 1982	25b. REGISTRAR'S SIGNATURE <u>Sam J. Connel</u>

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THE UNIVERSITY OF CHICAGO

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Figure 1. The first 20

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 3 0 2			
1. FOR STATE REGISTRAR		REG. NO.											
1. DECEASED NAME (TYPE OR PRINT)		FIRST <i>James</i>		MIDDLE <i>L.</i>		LAST <i>Tyler</i>		2a. DATE OF DEATH		MONTH <i>10</i>	DAY <i>5</i>	YEAR <i>82</i>	2b. HOUR <i>12:40</i>
3. SEX <i>male</i>		4. RACE <i>white</i>		5. DATE OF BIRTH		MONTH <i>10</i>		DAY <i>18</i>		YEAR <i>99</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>82</i>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Ret. Dispatcher</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Tool</i>		MD	
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Good Samaritan Hospital</i>		12c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13a. STATE <i>MD</i>		13b. COUNTY		13c. CITY OR TOWN <i>Baltimore</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME		FIRST <i>Daniel</i>		MIDDLE <i>W.</i>		LAST <i>Tyler</i>		15. MOTHER'S MAIDEN NAME		FIRST <i>Johannah</i>		MIDDLE <i>Leahy</i>	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>No</i>		16b. SOCIAL SECURITY NO. <i>212-10-6668</i>		17. INFORMANT		ADDRESS <i>Mrs. Thelma C. Tyler Same as # 13c</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:													
IMMEDIATE CAUSE (a) <i>Terminal Pneumonia</i>													
1629 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.													
(b) <i>Lung Cancer</i>													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>P.M. 19</i>				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE <i>KHAIRY W. Malek M.D.</i>								DEGREE <i>PHYSICIAN</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>KHAIRY W. Malek</i>								22e. ADDRESS <i>The Good Samaritan Hospital Baltimore</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>				23b. DATE <i>10/8/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Moreland Mem. Park</i>				23d. LOCATION CITY OR TOWN COUNTY STATE <i>Baltimore, Maryland</i>			
24. FUNERAL DIRECTOR NAME <i>Leonard J. Ruck, Inc.</i>								ADDRESS <i>Baltimore, Md.</i>		25a. DATE REC'D. BY REGISTRAR <i>OCT 6 1982</i>			
								REGISTRAR'S SIGNATURE <i>John J. Connel</i>					

MEDICAL CERTIFICATION

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

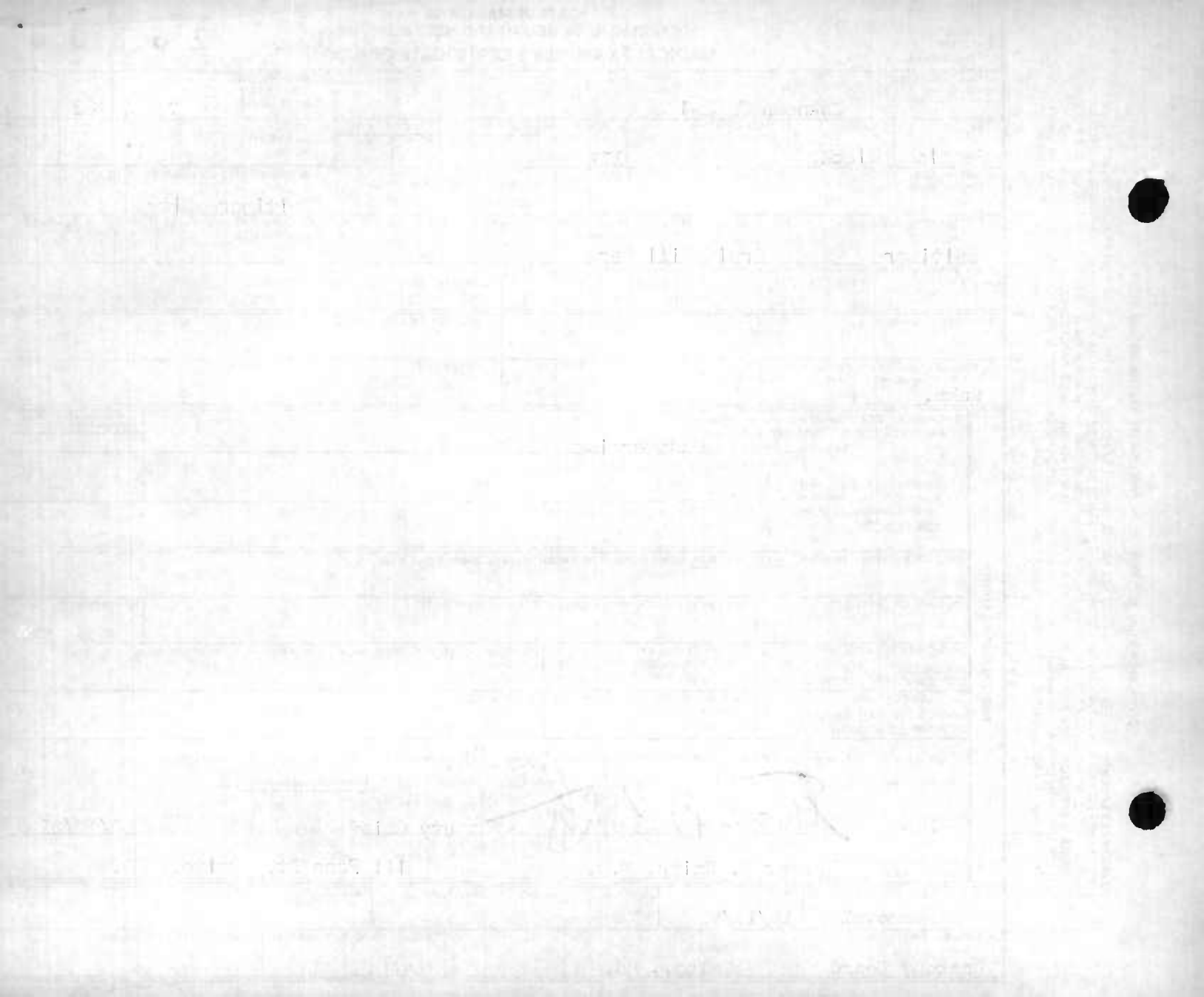
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20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR		2. DATE KNOWN OF DEATH		3. DATE KNOWN ESTI- MATED		4. MONTH		5. DAY		6. YEAR		7. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2. DATE KNOWN OF DEATH		3. DATE KNOWN ESTI- MATED		4. MONTH	
Unknown # 82-100												5. DAY	
6. YEAR		7. HOUR		8. MONTH		9. DAY		10. YEAR		11. HOUR		12. MIN.	
13. SEX		14. RACE		15. DATE OF BIRTH		16. AGE (IN YEARS)		17. IF UNDER 1 YR.		18. IF UNDER 24 HRS.		19. DATE PRONOUNCED DEAD	
Female		Black		177 YRS.				MONTHS		DAYS		HOURS	
20. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		21. CITIZEN OF WHAT COUNTRY?		22. MARRIED		23. NEVER MARRIED		24. WIDOWED		25. DIVORCED		26. BALTIMORE CITY OR COUNTY OF DEATH	
Baltimore		Baltimore		YES		NO		YES		NO		Baltimore City, MD.	
27. CITY OR TOWN OF DEATH		28. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		29. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		30. KIND OF BUSINESS OR INDUSTRY		31. BALTIMORE CITY OR COUNTY OF DEATH		32. BALTIMORE CITY OR COUNTY OF DEATH		33. BALTIMORE CITY OR COUNTY OF DEATH	
Baltimore		Druid Hill Park											
34. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		35. STATE		36. COUNTY		37. CITY OR TOWN		38. INSIDE CITY LIMITS?		39. STREET ADDRESS		40. STREET ADDRESS	
								YES		NO			
41. FATHER'S NAME		42. MOTHER'S MAIDEN NAME		43. FATHER'S NAME		44. MOTHER'S MAIDEN NAME		45. FATHER'S NAME		46. MOTHER'S MAIDEN NAME		47. FATHER'S NAME	
FIRST		MIDDLE		LAST		FIRST		MIDDLE		LAST		FIRST	
48. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		49. (IF YES, GIVE WAR OR DATES)		50. SOCIAL SECURITY NO.		51. INFORMANT		52. ADDRESS		53. ADDRESS		54. ADDRESS	
Unkn.													
55. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY:		56. IMMEDIATE CAUSE (a) <u>Undetermined</u>		57. DUE TO, OR AS A CONSEQUENCE OF		58. IMMEDIATE CAUSE (b)		59. DUE TO, OR AS A CONSEQUENCE OF		60. IMMEDIATE CAUSE (c)		61. DUE TO, OR AS A CONSEQUENCE OF	
7999													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).		62. DATE OF OPERATION		63. CONDITION FOR WHICH OPERATION WAS PERFORMED?		64. AUTOPSY?		65. YES		66. NO		67. YES	
68. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		69. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		70. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)		71. LOCATION		72. CITY OR TOWN		73. COUNTY		74. STATE	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		21g. CITY OR TOWN		21h. COUNTY		21i. STATE		21j. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
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21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
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21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
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21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
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21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
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21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c. HOW INJURY OCCURRED		21d. LOCATION		21e. CITY OR TOWN		21f. COUNTY		21g. STATE	
21a. INJURY OCCURRED		21b. PLACE OF INJURY		21c									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 0 4

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Maryanna (Marjanna) Uzarowski			2a. DATE OF DEATH MONTH DAY YEAR 10 31 1982			2b. HOUR M M				
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8 30 1895		6. AGE (IN YEARS LAST BIRTHDAY) 87		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Poland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) So. Baltimore General Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3830 Brooklyn Ave. (21225)	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Wojkowski			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 215-09-3400		17. INFORMANT ADDRESS Matilda C. Degges (same as 13e)					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) Intractable congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH YRS										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9:28 10 19 82		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 9:28 , 19 81 , to 10:18 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE Lorraine M. Dailey MD						22c. DATE SIGNED 11/2/82				
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Lorraine M. Dailey M.D.						22e. ADDRESS 8667 Ft. Smallwood Rd. Pasadena Md.				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/3/82		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME ADDRESS George J. Gonce F.H. 4001 Ritchie Hgwy. Balto., Md. 21225						25a. DATE REC'D. BY REGISTRAR NOV 3 1982		25b. REGISTRAR'S SIGNATURE John J. Conner		

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DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) Thomas Edgar Vaeth			2a. DATE KNOWN OF DEATH MONTH 10 DAY 29 YEAR 1982			2b. HOUR 8:01		
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH Oct DAY 14 YEAR 1935	6. AGE (IN YEARS) LAST BIRTHDAY 47 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH 10 DAY 29 YEAR 1982		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Front of 3212 Pelham Avenue				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Truck Driver		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 21206 4606 Benton Heights Ave		
14. FATHER'S NAME FIRST Edgar MIDDLE LAST			15. MOTHER'S MAIDEN NAME FIRST Doris MIDDLE LAST Kennard			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		
16b. SOCIAL SECURITY NO. 212-32-6988			17. INFORMANT Mrs Sara G Vaeth			ADDRESS 1302 Hillsway Court		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
ACTUAL SIGNATURE Hormez R. Guard			TITLE (SPECIFY) M.D. Assistant			DATE SIGNED 10/30/82		
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.			ADDRESS 111 Penn Street Baltimore, MD 21201					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) XXXXXX Cremation			23b. DATE 11/2/82		23c. NAME OF CEMETERY OR CREMATORY Greenmount		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME Leonard J Ruck Inc.					ADDRESS Baltimore, Maryland		25a. DATE REC'D. BY REGISTRAR NOV 1 1982	
					25b. REGISTRAR'S SIGNATURE John J. Lough			

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PW 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26306	
1- FOR STATE REGISTRAR			1. DECEASED NAME (TYPE OR PRINT)		John Valentine		2a. DATE OF DEATH		2b. HOUR		
			3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		
			Male		Black		8/6/46		36 YRS.		
			7a. BIRTHPLACE (STATE OR COUNTY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		9. BALTIMORE CITY OR COUNTY OF DEATH		
			Balto., MD		U.S.A.		NEVER MARRIED		Baltimore City MD.		
			10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
			Baltimore		Maryland General Hospital		Contract Wkr-Disab				
			13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		
			MD				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
			14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16a. WAS DECEASED EVER IN U.S. ARMED FORCES?		16b. SOCIAL SECURITY NO.		
			Johnny Strong		Anita Fields		No				
			17. INFORMANT		ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
			Anita Fields		571 Pressman Street		PART I DEATH WAS CAUSED BY:				
							IMMEDIATE CAUSE (a) Pneumonia				
							DUE TO, OR AS A CONSEQUENCE OF				
							(b)				
							DUE TO, OR AS A CONSEQUENCE OF				
							(c)				
			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).								
			19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?				
							YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
			21a. EXTERNAL CAUSE WAS		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED				
			UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		HOUR A.M. MONTH DAY YEAR		ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2				
			21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION				
			WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				CITY OR TOWN		COUNTY STATE		
			22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion						
			death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .								
			ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED				
			Hormez R. Guard, M.D.		Assistant		10/12/82				
			EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS		111 Penn Street, Balto., MD 21201				
			23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION		
			Burial		10/16/82		Mt. Auburn Cemetery		Baltimore MD		
			24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
			Wm C. Brown Comm. F/H 1206-08 W. North Ave-		OCT. 19 1982		John J. Conish				

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UNITED STATES OF AMERICA

DEPARTMENT OF THE ARMY

HEADQUARTERS, ARMY

WASHINGTON, D.C. 20315

UNITED STATES OF AMERICA

DEPARTMENT OF THE ARMY

WASHINGTON, D.C. 20315

UNITED STATES OF AMERICA
DEPARTMENT OF THE ARMY
WASHINGTON, D.C. 20315

UNITED STATES OF AMERICA
DEPARTMENT OF THE ARMY
WASHINGTON, D.C. 20315

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH PAGES 3 AND 4 AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

Items #18a-22a Film G575 1/3/83
 STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE KNOWN OF DEATH		MONTH		DAY		YEAR		2b. HOUR	
Robert		G.		Valentine, III				<input checked="" type="checkbox"/> MONTH		10		22		1982		M	
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (IN YEARS)		IF UNDER 1 YR.		IF UNDER 24 HRS.		7c. DATE PRONOUNCED DEAD		MONTH		DAY		YEAR	
Male	White	Oct. 23, 1955		26		MONTHS		DAYS		10		22		1982		11:13 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH											
Baltimore, Md.		U. S. A.				Baltimore City, MD.											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY											
Baltimore		Johns Hopkins Hospital		Water Maint. Dept. Balto.													
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS									
Md.		----		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		128 N. Luzerne Ave. 21224.									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME															
Robert		G. Valentine, Jr.		Faith		A. Broyles											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS											
No		---		219-62-4355		Mrs. Faith A. Tenace-1101 N. Calvert St. 21202.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART I DEATH WAS CAUSED BY:		IMMEDIATE CAUSE (a) <u>Intravenous Narcotism</u>		DUE TO, OR AS A CONSEQUENCE OF											
3049						(b) _____		DUE TO, OR AS A CONSEQUENCE OF									
						(c) _____											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?													
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>													
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B PART 1 OR PART 2)													
		HOUR A.M. MONTH DAY YEAR															
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION													
				STREET		CITY OR TOWN		COUNTY		STATE							
22a. I certify that I took charge of the remains described above, held on		Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion															
death resulted from		Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>															
ACTUAL SIGNATURE		TITLE (SPECIFY)		DATE SIGNED													
Dennis F. Smyth, M.D.		Assistant		10-23-82													
EXAMINER'S NAME (TYPE OR PRINT)		Dennis F. Smyth, M.D.		ADDRESS		111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION											
Burial		10/26/82		Holy Redeemer Cemetery - Baltimore, Maryland		COUNTY		STATE									
24. FUNERAL DIRECTOR NAME		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
John A. Moran, Inc.		OCT 27 1982		John J. Carver													
3000 E. Baltimore St. - Baltimore, Md. 21224																	

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1- FOR STATE REGISTRAR		Item 22a Film 572		DEPARTMENT OF HEALTH AND MENTAL HYGIENE		MEDICAL EXAMINER'S CERTIFICATE OF DEATH		REG. NO. 2 2 6 3 0 8	
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE KNOWN OF DEATH				2b. HOUR	
Jean Deatrice Van Horn				ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 2 1982				M 4:20 P	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)	7. IF UNDER 1 YR.	8. IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD		2d. HOUR	
Female	White	Dec. 11, 1922	59 YRS.	MONTHS	DAYS	10 2 1982		M 4:20 P	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH			
New York		U.S.A.				Baltimore City, MD.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		2712 Erdman Avenue				Housewife		Own Home	
13a. STATE		13b. CITY OR TOWN		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland		-----		Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2712 Erdmand Ave. 21213	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME					
Charles White				Madeline N/A					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address # Box 33			
No		-----		Christal Nadler Horseshoe Bch, Fla.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9530 IMMEDIATE CAUSE (a) <u>Hanging</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the <u>underlying cause last</u> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?			
						YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
		HOUR A.M. MONTH DAY YEAR ? P.M. 10 2 1982		Subject hanged self					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION		CITY OR TOWN		COUNTY STATE	
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		home		2712 Erdman Ave.		Balto.		Md	
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE		TITLE (SPECIFY)				DATE SIGNED			
		M.D. Deputy Chief, MEDICAL EXAMINER				10/3/82			
EXAMINER'S NAME (TYPE OR PRINT)		ADDRESS							
THOMAS D. SMITH, M.D.		111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION			
Burial		10/6/82		Butler Cemetery		Dixie Co. Fla.			
24. FUNERAL DIRECTOR		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
E. Barnes		21018		OCT 13 1982					
NAME Fleming Funeral Service		ADDRESS Benson, Md.							

Service

Amesbury Mass. 12.19.22

New York

Dear Sir,
I have the honor to acknowledge the receipt of your letter of the 11th inst. regarding the matter of the late Mr. J. H. [Name] and in reply to inform you that the same has been forwarded to the proper authorities for their consideration.

I am, Sir, very respectfully,
Yours truly,
[Signature]

Very truly yours,
[Signature]

[Signature]

[Signature]

[Signature]

[Signature]

Very truly yours,
[Signature]



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND											
DEPARTMENT OF HEALTH AND MENTAL HYGIENE											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
REG. NO. 2 26309											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mary L. Vann						2a. DATE KNOWN OF DEATH MONTH DAY YEAR 10 24 1982		2b. HOUR a.m. p.m. 2:10 a.m.			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 2 23 25		6. AGE (IN YEARS) LAST BIRTHDAY 57 YRS		7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN			
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND			9. CITIZEN OF WHAT COUNTRY? US			10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			11. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.		
12. CITY OR TOWN OF DEATH Baltimore			13. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2708 W. North Avenue				14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE			15. KIND OF BUSINESS OR INDUSTRY	
16a. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND			13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2708 W. NORTH AVE. 21216		
14. FATHER'S NAME FIRST MIDDLE LAST James Lewis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST GEORGIA WILSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) no				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS THELMA ROBINSON 1730 N. APPLETON ST.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Cardiovascular Disease</u> <u>4292</u> Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Dennis F. Smyth, M.D.</u>				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 10-24-82			
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10-30-82		23c. NAME OF CEMETERY OR CREMATORY MT. CALVARY			23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE MARYLAND			
24. FUNERAL DIRECTOR NAME E.L. PHILLIPS						ADDRESS 1721 N. MONROE ST.		25a. DATE REC'D. BY REGISTRAR OCT 28 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>	

BP

RECEIVED
JAN 10 1964
U.S. AIR FORCE
HEADQUARTERS
WASHINGTON, D.C.

RECEIVED
JAN 10 1964
U.S. AIR FORCE
HEADQUARTERS
WASHINGTON, D.C.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 3 1 0 REG. NO.			
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANTHONY T. VATAKIS						2a. DATE OF DEATH MONTH DAY YEAR 9 30 82		2b. HOUR 1 45 PM			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 7 25 24		6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Distriuber		12b. KIND OF BUSINESS OR INDUSTRY VUP Bottle Co.					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE COUNTY Maryland BALTO.						13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13c. STREET ADDRESS 3397 Dulaney Street 21229					
14. FATHER'S NAME FIRST MIDDLE LAST Theodore A. Vatakis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Unknown									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II		17. INFORMANT 250-18-2411		ADDRESS Rosemary Vatakis 3397 Dulaney Street		21229					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) RESPIRATORY FAILURE DUE TO, OR AS A CONSEQUENCE OF (b) METASTATIC CA DUE TO, OR AS A CONSEQUENCE OF (c) LUNG CA - ADENOCARCINOMA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH wks 8 mos 8 mos			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHERE <input type="checkbox"/> NO WHERE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from FEB 9 19 82 to SEPTEMBER 30 19 82, that (I) (we) last saw the deceased alive on SEPTEMBER 30 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death.)													
22b. SIGNATURE Dr. Griffiths		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/4/82							
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Griffiths		22e. ADDRESS St. Agnes Hospital 3rd Flr											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/4/82		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland							
24. FUNERAL DIRECTOR NAME Hubbard Funeral Home, Inc.		ADDRESS 21229 4107 Wilkens Ave.		25a. DATE REC'D. BY REGISTRAR OCT 4 - 1982		25b. REGISTRAR'S SIGNATURE John J. Connel							



TO		FROM		SUBJECT	
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 15 DAYS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE-
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) EDITH VAUGHN			2a. DATE OF DEATH KNOWN ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 15 1982			2b. HOUR M 4:19			
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 12 3 1926	6. AGE (IN YEARS) LAST BIRTHDAY YRS. 55	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 15 1982			2d. HOUR a M 4:19
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 400 N. Denison St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 400 N. Denison Street	
14. FATHER'S NAME FIRST MIDDLE LAST Thomas Jones				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lavina Knox					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 215-22-7486		17. INFORMANT ADDRESS Rudolph Vaughn 400 N. Denison Street			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) Lung cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE 			TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER				DATE SIGNED 10-15-82		
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/18/82		23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland		
24. FUNERAL DIRECTOR NAME Wm. C. March F/H, Inc.				ADDRESS 1101 E. North Avenue		25a. DATE REC'D. BY REGISTRAR OCT 18 1982		25b. REGISTRAR'S SIGNATURE 	

01200-111B

2000-111B



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified & one.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 1 2

1- FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR	
DALLAS				VINSON	10-10-82					1255 AM	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
Male	Black		MONTH 2 DAY 8 YEAR 28		54 YRS		MONTHS DAYS		HOURS MIN.		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
N. Carolina	USA				BALTIMORE CITY MD.						
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY			
BALTIMORE	UNION MEMORIAL HOSPITAL										

13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS	
Maryland				Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		622 Cokebury Avenue	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME				
FIRST MIDDLE LAST James Vinson					FIRST MIDDLE LAST Emma Velines				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No				246-44-5542		Williw Wiley 1604 Montpelier St.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST			
1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			
(b)			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			
LUNG CANCER, BRAIN ABSCESS			

19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?
		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>

21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)

21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from 10/9 to 10/10 1982, that (I) (we) lost saw the deceased alive on 10/9, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did (did not) view the body after death.	
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22b. SIGNATURE <i>Robert J. Varipapa</i>	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/10/82
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22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT J. VARIPAPA MD	22e. ADDRESS UNION MEMORIAL HOSPITAL
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23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 10/15/82	23c. NAME OF CEMETERY OR CREMATORY Union Grove Bapt Ch Hurdle Mills	23d. LOCATION CITY OR TOWN COUNTY STATE N. C.
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24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North avenue	25a. DATE REC'D. BY REGISTRAR OCT 13 1982	25b. REGISTRAR'S SIGNATURE <i>John J. Connel</i>
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11

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 1 3

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			2b. HOUR		
WENDELL A. VOLLMER SR.			OCT. 23, 1982			10:14P		
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)			7. IF UNDER 1 YEAR		
Male	White	Aug. 7, 1913	69 YRS.			MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	9. CITIZEN OF WHAT COUNTRY?	10. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			11. BALTIMORE CITY OR COUNTY OF DEATH			12. BALTIMORE CITY MD.
Maryland	USA	THE JOHNS HOPKINS HOSPITAL			BALTIMORE CITY			MD.
13. CITY OR TOWN OF DEATH	14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			15. 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY	
BALTIMORE	13a. STATE 13b. COUNTY 13c. CITY OR TOWN Md. Howard Ilchester			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			13e. STREET ADDRESS Ilchester 21083 4751 Ilchester Rd.	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16. ADDRESS		
Wendell A. Vollmer			Rosa Hupp			Rd., 21083		
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)			18. SOCIAL SECURITY NO.			19. INFORMANT		
No			212-32-8596			Mrs. Agnes M. Vollmer, 4751 Ilchester		

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:		2 hrs.	
4149 IMMEDIATE CAUSE (a) Cardiogenic shock			
DUE TO, OR AS A CONSEQUENCE OF		10 yrs.	
(b) Coronary artery disease			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR					
		P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY		21f. LOCATION			
WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/>		AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/23, 19 82, to 10/23, 19 82, that (I) (we) last saw the deceased alive on 10/23, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.							
22b. SIGNATURE		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
James K. Porterfield		M.D.				10/23/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS					
James K. Porterfield		Johns Hopkins Hospital					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION
Burial	10/28/82	New Cathedral Cem.	Baltimore City, Md.

24. FUNERAL DIRECTOR	25a. DATE REC'D. BY REGISTRAR	25b. REGISTRAR'S SIGNATURE
Lemmon-Mitchell-Wiedefeld, 10 W. Padonia Rd.	OCT 28 1982	John J. Lohr

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires the death certificate to be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it should be completely filled in by the funeral director. It should be detached for use as the burial-transit permit. Then please remove and give to the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

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1000 20% COIT

PHILIP

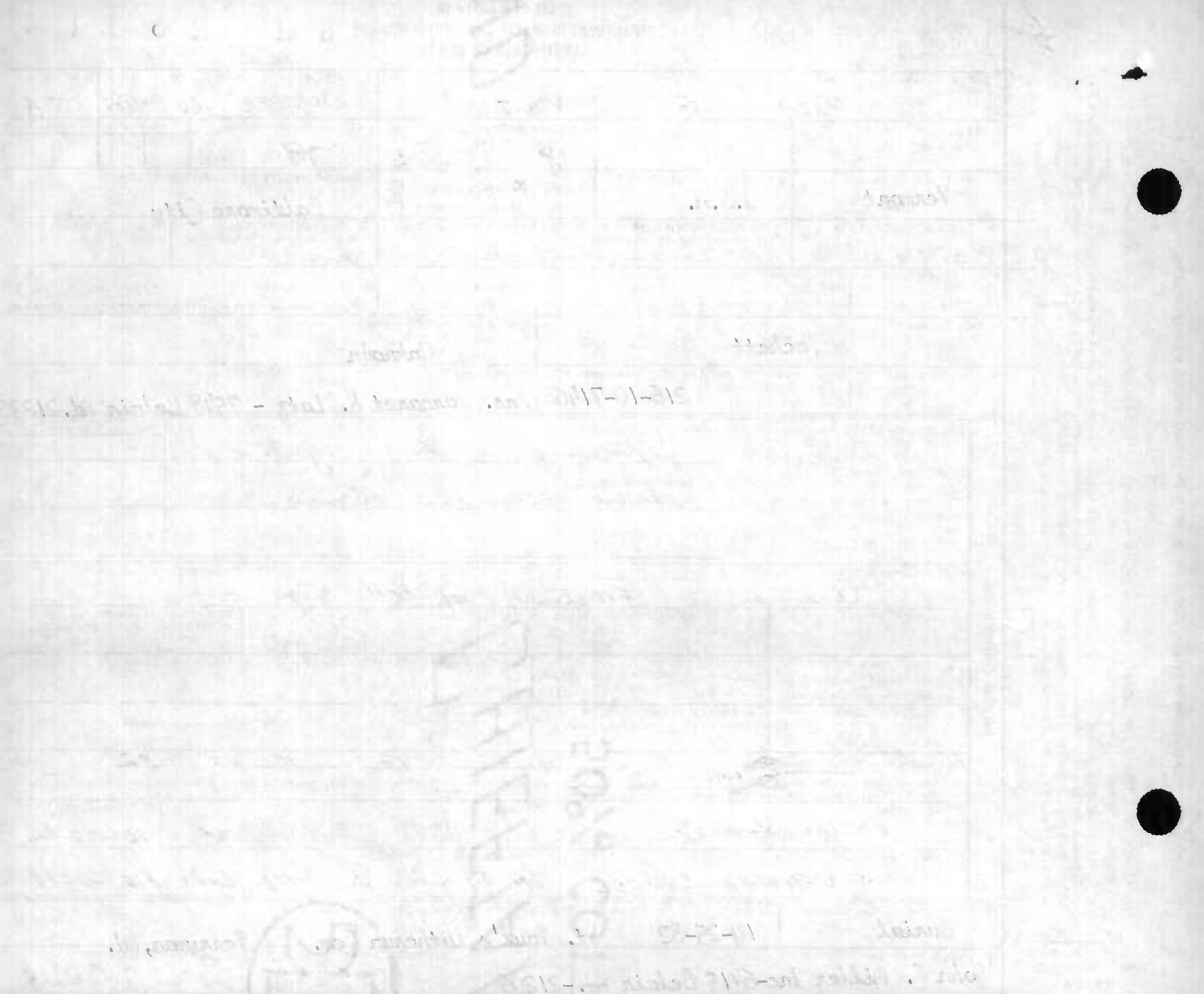
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or an autopsy performed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 6 3 1 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) <u>MARY G. VOLZ</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>OCTOBER 22 1982</u> 2b. HOUR <u>3:55 A.M.</u>			
3. SEX <u>F</u>		4. RACE <u>W</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>8-1-03</u>		6. AGE (IN YEARS LAST BIRTHDAY) <u>79</u> YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Vermont</u>		7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>N. C. H. - 28th & Charles St.</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>dis able</u>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE <u>md.</u>		13b. COUNTY		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST <u>HACKETT</u> MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST <u>Unknown</u> MIDDLE LAST		13e. STREET ADDRESS <u>801 St Paul St. midtown</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>no</u>		16b. SOCIAL SECURITY NO. <u>216-10-7146B</u>		17. INFORMANT ADDRESS <u>Mrs. Margaret K. Lotz - 7548 Belair Rd. 21236</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>7070</u> IMMEDIATE CAUSE (a) <u>Septicemia Gram negative</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>severe decubitus ulcer</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>7070</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <u>Anemia</u> <u>Fracture of both hips</u>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>P.M. 19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>9-27</u> , 19 <u>82</u> , to <u>10-22</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>October 22 19 82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Myers</u>		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10-22-82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>C. VERGARA - SOARES</u>		22e. ADDRESS <u>N. Charles Gen. Hosp. Balt. MD. 21218</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>10-25-82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>St. Paul's Lutheran Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Perryman Md.</u>	
24. FUNERAL DIRECTOR NAME <u>John C. Miller Inc-6415 Belair Rd.-21206</u> ADDRESS				25a. DATE REC'D. BY REGISTRAR <u>OCT 26 1982</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 checked, any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) August J. Wachsmuth Jr.			2a. DATE OF DEATH MONTH DAY YEAR 10 - 28 - 1982			2b. HOUR 11 50 A M			
3. SEX Male		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 10 12 17		6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore, City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumber		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 6 Anika Ct. Catonsville, Md. 21228	
14. FATHER'S NAME FIRST MIDDLE LAST August J. Wachsmuth, Sr.			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bessie M. Flood						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) W.W. 2		17. INFORMANT Mrs. Betty Wachsmuth, Same as above		ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1519 IMMEDIATE CAUSE (a) Carcinoma of the stomach DUE TO, OR AS A CONSEQUENCE OF (b) Metastasis DUE TO, OR AS A CONSEQUENCE OF (c) 								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9-14-82 , 19 82 , to 10-28 , 19 82 , that (I) (we) last saw the deceased alive on 10-28 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Faiz M. Behsudi, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10-28-1982	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Faiz M. Behsudi				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 1, 1982		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Park -		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie, A.A. Co. Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS McCuty Funeral Home, 130 E. Fort Ave. Balto. Md. 21230				25a. DATE REC'D. BY REGISTRAR NOV 1 1982		25b. REGISTRAR'S SIGNATURE Joan J. Conner			

MEDICAL CERTIFICATION



NOTICE

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon-papers. Pages 3 and 4 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 2 6 3 1 6		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HARRY W WACHTER				2a. DATE OF DEATH MONTH DAY YEAR 10 14 82		2b. HOUR 8¹⁰ A.M.	
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 01 13 1920		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 62 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH city MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. Md Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) PRINTER		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. CITY OR TOWN Baltimore Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13d. STREET ADDRESS 7920 Rolling View Ave	
14. FATHER'S NAME FIRST MIDDLE LAST Lester Wachter				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Marie Hoffman			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WW II		16b. SOCIAL SECURITY NO. 212-01-4357		17. INFORMANT ADDRESS Mrs. Rose F. Wachter 7920 Rolling View Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1889 IMMEDIATE CAUSE (a) Cardio-pulmonary arrest DUE TO, OR AS A CONSEQUENCE OF (b) Metastatic carcinoma of the urinary bladder DUE TO, OR AS A CONSEQUENCE OF (c) Bilateral ureteral obstruction							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 month
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Bilateral ureteral obstruction							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 9/30 , 19 82 , to 10/14 , 19 82 , that (I) (we) lost saw the deceased alive on 10/14 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE L. Rezirdian				DEGREE M.D.		22c. DATE SIGNED 10/14/82 8 PM	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) REZIRDIAN LAWRENCE				22e. ADDRESS Univ. Md Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/6/82		23c. NAME OF CEMETERY OR CREMATORY Gardens of Faith		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR NAME Lassahn Funeral Home				25a. DATE RECD. BY REGISTRAR 10/11/82			
ADDRESS 7401 Belair Rd.				25b. REGISTRAR'S SIGNATURE [Signature]			

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British American Univ. Med. Hospital

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mammary gland

Biological material observation

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British American Univ. Med. Hospital

Residence in Lawrence Univ. Med. Hospital

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT)		FIRST CLAYTON	MIDDLE B.	LAST WAGANER	2a. DATE OF DEATH MONTH DAY YEAR 10 6 82			2b. HOUR 1:20P M	
3. SEX M	4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 2/25/23		6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS			7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (COUNTRY) MISSOURI	7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC LOCH RAVEN BLVD BALTO MD			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNK		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY MD BALTO				13c. CITY OR TOWN EAST POINT		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 21224 469 MIRABLE LN	
14. FATHER'S NAME FIRST MIDDLE LAST ERNEST WAGANER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MABEL BARNETT						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) UNK II 505 26 0593		17. INFORMANT ADDRESS JIM WAGANER FREELAND MD				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4280 IMMEDIATE CAUSE (a) CONGESTIVE HEART FAILURE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that X (this hospital) attended the deceased from October 1, 1982, to October 6, 1982, that X (we) last saw the deceased alive on October 6, 1982, and that in X (our) opinion death occurred on the date and hour and from the causes stated above, X (we) (did) (did not) view the body after death.									
22b. SIGNATURE Marc Okun, MD			DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>			22c. DATE SIGNED 10/6/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) MARC OKUN, MD			22e. ADDRESS 3900 Loch Raven Blvd. Balto. Md 21218						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/9/82		23c. NAME OF CEMETERY OR CREMATORY HOLLY HILL		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD			
24. FUNERAL DIRECTOR NAME J.G. CONNELLY			ADDRESS 300 MACE			25a. DATE REC'D. BY REGISTRAR OCT 13 1982		25b. REGISTRAR'S SIGNATURE John J. Connel	

BURIAL

1-1/2

1-1/2

1-1/2

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10/10/05

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 1 8

REG. NO.

1. FOR STATE REGISTRAR		2a. DATE OF DEATH		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH		2b. HOUR	
Katheryn Boyd Waidner		10/25/82		2:58 AM	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE	7. BALTIMORE CITY OR COUNTY OF DEATH	
Female	White	June 24 1904	78	Baltimore City MD.	
7a. BIRTHPLACE	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH		
Maryland	U.S.A.		Baltimore City MD.		
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Long Green N.H.		Homemaker		
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET ADDRESS	
Maryland		Baltimore	YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	100 W. University Pkwy. 21210	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME			
Jesse Cookman Boyd		Hallie Antoinette Smith			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)	16b. SOCIAL SECURITY NO.	17. INFORMANT ADDRESS			
No	220-09-2263	Mr. J. Cookman Boyd 1000 Winding Way 21210			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral C Metastases</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>CVA.</u>					
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
			YES <input type="checkbox"/> NO <input type="checkbox"/>	YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR (A.M.) MONTH DAY YEAR P.M. 10/25/82	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>12/28/81</u> 19 <u>10/25</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>10/25</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>Dr. F.M. Dugan</u>		22c. DATE SIGNED 10/25/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS		22f. DEGREE	
Dr. F.M. Dugan		15 E. Biddle St		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION CITY OR TOWN COUNTY STATE		
Burial	10-27-82	Druid Ridge Cemetery	Pikesville Baltimore Md		
24. FUNERAL DIRECTOR NAME ADDRESS		25a. DATE REC'D. BY REGISTRAR			
Mitchell-Wiedefeld Home 6500 York Rd 21212		OCT 29 1982			
		25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the death certificate with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified and a post-mortem examination will be required.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 1 9
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
		Joseph J. WAJER		October 15, 1982		4:00a M	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)	
MALE		WHITE		5 30 1916		66 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
MARYLAND		U.S.A.				Baltimore City MD.	
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Maryland General Hospital		SALES		ATLANTIC FISH	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE		13b. COUNTY		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS	
MARYLAND		BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		627 S. LINWOOD AVE.	
14. FATHER'S NAME FIRST MIDDLE LAST		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO.	
PETER WAJER		LAURA GLEBA		WWII YES ARMY		31309 8913	
17. INFORMANT ADDRESS		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory failure,</u> <u>1629</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia and Sepsis and</u> (c) <u>Carcinoma of the LUNG with metastases</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
JOSEPHINE WATER		627 S. LINWOOD AVE					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M.		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
		19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that XX (this hospital) attended the deceased from <u>October 14</u> , 19 <u>82</u> , to <u>October 15</u> , 19 <u>82</u> , the XX (we) last saw the deceased alive on <u>October 15</u> , 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If we) (did) (did not) view the body after death.							
22b. SIGNATURE		22c. DATE SIGNED		22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS	
Janice Rutkowski, M.D.		10/15/82		Janice Rutkowski, M.D.		c/o Maryland General Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		10-19-1982		SACRED HEART JESUS		BALTIMORE MD.	
24. FUNERAL DIRECTOR NAME		24b. ADDRESS		25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Raymond L. Kaczorowski		2525 Fleet St.		OCT 18 1982		John J. Conner	

100-441100

October 12, 1952

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Respiratory failure

Pneumonia and shock

Location of the line with metastases

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October 12, 1952

October 12

October 12

xxx

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by the attending physician.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 2 0

REG. NO.

FOR
STATE
REGISTRAR

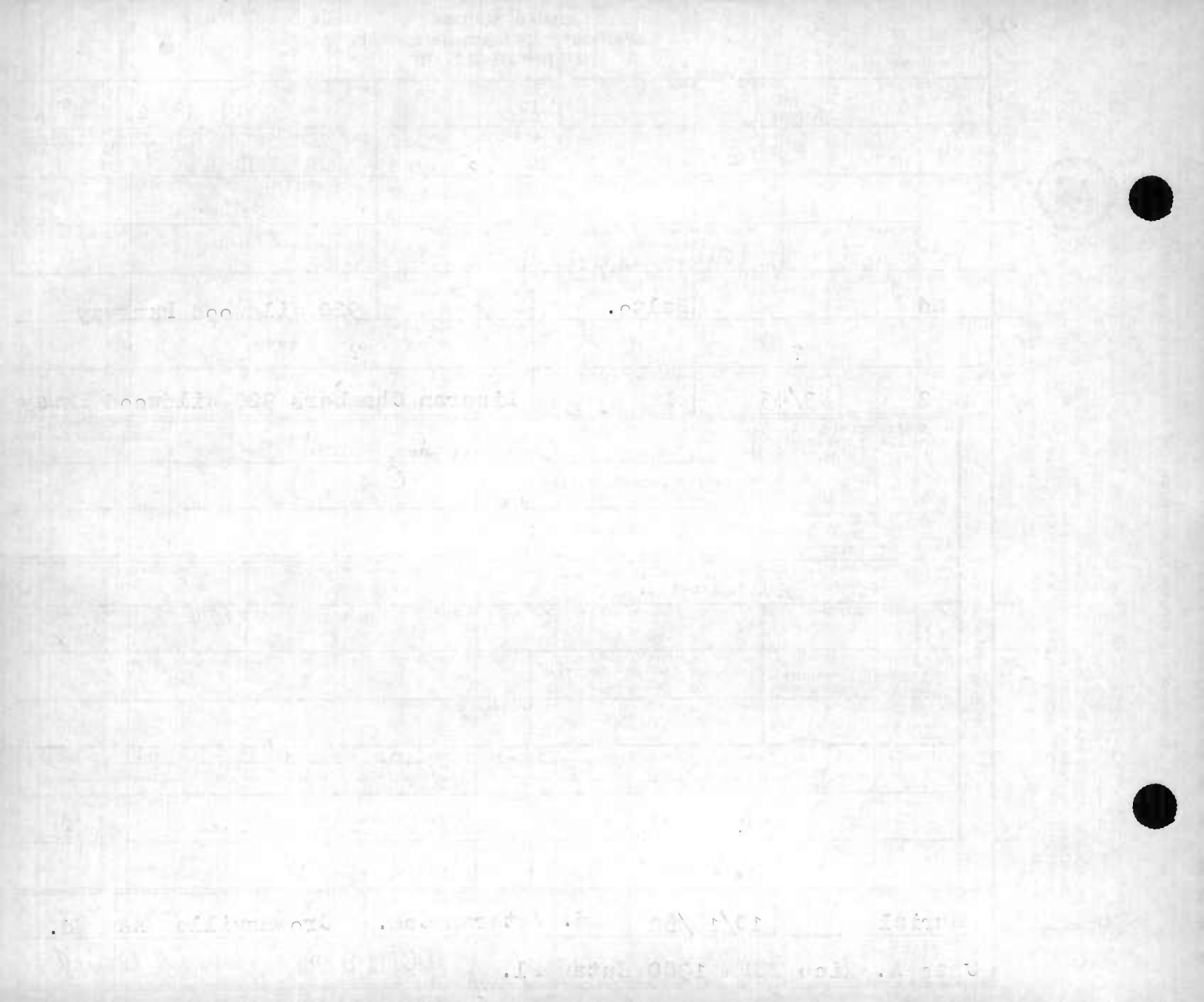
1. DECEASED NAME (TYPE OR PRINT) Charles H. Waldron			2a. DATE OF DEATH MONTH DAY YEAR 10-17-82		2b. HOUR 3:15 A M	
3. SEX MALE		4. RACE CAU.		5. DATE OF BIRTH MONTH DAY YEAR 7 22 06		6. AGE (IN YEARS LAST BIRTHDAY) 76
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) T.L. Deaton 611 S. Charles St.		12a. USUAL OCCUPATION (STATE OF WORK FOR MOST OF WORKING LIFE) CORE MAKER		12b. KIND OF BUSINESS OR INDUSTRY STEEL
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST HUGH WALDRON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MINNIE WHELLER		13e. STREET ADDRESS 1231 W. BALTIMORE ST.		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 216-01-9148A		17. INFORMANT ADDRESS MADeline WALDRON 1231 W. BALTIMORE		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4360 IMMEDIATE CAUSE (a) Respiratory Failure DUE TO, OR AS A CONSEQUENCE OF: (b) Pneumonia DUE TO, OR AS A CONSEQUENCE OF: (c) Cerebral Vascular Accident						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 9/27/82 10/18/82
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 9/22 , 19 82 , to 10/17 , 19 82 , that (I) (we) lost saw the deceased alive on 10/16 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE K.M. Sanzaro MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/18/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) K. SANZARO, MD				22e. ADDRESS Deaton Medical Center		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-20-82		23c. NAME OF CEMETERY OR CREMATORY OAKLAND		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO MD.
24. FUNERAL DIRECTOR NAME Dick Nove + Sons				ADDRESS 322 S. High St		25a. DATE REC'D. BY REGISTRAR OCT 19 1982
						25b. REGISTRAR'S SIGNATURE John J. Conner

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the medical examiner, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										
1. FOR STATE REGISTRAR		REG. NO. 8 2 2 6 3 2 1								
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Edward Walker					2a. DATE OF DEATH MONTH DAY YEAR 10 13 82			2b. HOUR 4 ²⁰ a.m.		
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 06 05 06		6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.				
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Lutheran Hospital of Md.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md					13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST ? ? ?					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ? ? ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) WW 2		16b. SOCIAL SECURITY NO. 43/45		17. INFORMANT ADDRESS Lizeran Chambers 920 Wildwood Pkwy						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 0389 IMMEDIATE CAUSE (a) <u>Cardiorespiratory arrest</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Cerebrovascular accident</u>										
MEDICAL CERTIFICATION										
19a. DATE OF OPERATION None		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from 8/26, 19 82, to 10/13, 19 82, that (I) (we) lost saw the deceased alive on 10/13, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did not view the body after death.										
22b. SIGNATURE J. Ochida MD				DEGREE MD				22c. DATE SIGNED 10/13/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Ochida MD				22e. ADDRESS Lutheran Hosp. of Md.						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/18/82		23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville AA Md.				
24. FUNERAL DIRECTOR NAME Chas A. Rice FSPA 1300 Eutaw Pl.				25. DATE REC'D. BY REGISTRAR OCT 18 1982		25. REGISTRAR'S SIGNATURE John L. Conner				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified or cause.

MEDICAL CERTIFICATION

FOR 1. STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 6 3 2 2 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) James E Walker						2a. DATE OF DEATH MONTH DAY YEAR 10 27 82				2b. HOUR 5 A M		
3. SEX male		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 9 10 35		6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS 47		IF UNDER 24 HRS HOURS MIN. 47		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.						
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. of Md. hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unemployed			12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Md.				13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2113 W. mulberry st.		
14. FATHER'S NAME (PRINT) Albert MIDDLE Taylor LAST Walker				15. MOTHER'S MAIDEN NAME FIRST ANNIE MIDDLE B. LAST WALKER				16. ADDRESS 2113 W. Mulberry St				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Unknown		16b. SOCIAL SECURITY NO. 240-94-1473		17. INFORMANT Shirley Walker								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio respiratory Arrest 1629 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Squamous lung Ca DUE TO, OR AS A CONSEQUENCE OF (c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (1) (this hospital) attended the deceased from 10-12 , 19 82 , to 10-27 , 19 82 , that (1) (we) lost saw the deceased alive on 10-27 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death.												
22b. SIGNATURE Howard Freeland MD				DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-27-82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Howard Freeland MD				22e. ADDRESS 22 S. Greene St Balto Md 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/1/82		23c. NAME OF CEMETERY OR CREMATORY Mt Zion Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md				
24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Ave				ADDRESS 1101 E. North Ave				25. DATE REC'D. BY REGISTRAR NOV 1 1982		26. REGISTRAR'S SIGNATURE John J. Lohr		

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 6 3 2 3 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VERNITA RUSSELLA WALKER				2a. DATE OF DEATH MONTH DAY YEAR OCT. 20, 1982		2b. HOUR 3:14 A M	
3. SEX FEMALE		4. RACE R BLACK		5. DATE OF BIRTH MONTH DAY YEAR 10 16 1960		6. AGE (IN YEARS LAST BIRTHDAY) 22 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.Y.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		13b. COUNTY Balto.		13c. CITY OR TOWN RANDALSTOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST HASKEL WALKER		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HARRIET M. MADDEN		11. STREET ADDRESS 517 Gwynnvale Road 21208			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 111 52 1550		17. INFORMANT ADDRESS HARRIET M. ROBINSON 517 Gwynnvale Rd.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 2050 IMMEDIATE CAUSE (a) cardiac arrest DUE TO, OR AS A CONSEQUENCE OF (b) seizures and hepatic failure DUE TO, OR AS A CONSEQUENCE OF (c) acute myelocytic leukemia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/19 1982 , to 10/20 1982 , that (I) (we) lost saw the deceased alive on 10/20 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Robert I. Garver Jr MD DEGREE				22c. DATE SIGNED 10/20/82		22d. PHYSICIAN'S NAME (TYPE OR PRINT) ROBERT I. GARVER JR	
22e. ADDRESS JOHNS HOPKINS HOSP BALTIMORE							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-23-82		23c. NAME OF CEMETERY OR CREMATORY Kings Memorial Pk		23d. LOCATION CITY OR TOWN COUNTY STATE Randalstown Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Brown/Thompson Funeral Home 1913 W. Balto.				25a. DATE REC'D. BY REGISTRAR 22 1982 REGISTRAR'S SIGNATURE John J. Garver			

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WALKER

VERMONT

BALTIMORE CITY

THE JOHN W. WALKER FOUNDATION

RECEIVED

[Faint, illegible handwritten notes and signatures at the bottom of the page, possibly including a date like 10/10/32 and a signature.]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled within 48 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of the death.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 3 2 4			
1- FOR STATE REGISTRAR										REG. NO.			
1 DECEASED NAME (TYPE OR PRINT) BLANCHO R. WALLACE						2a. DATE OF DEATH MONTH DAY YEAR 10-27-82				2b. HOUR 2 15 AM			
3 SEX Male		4 RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 8 25 04		6 AGE (IN YEARS LAST BIRTHDAY) 78 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD							
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hosp.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY					
13a. STATE MD				13b. COUNTY Balto.		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 21217 1701 Eutaw Pl. Apt. 102					
14 FATHER'S NAME FIRST MIDDLE LAST Walter Wallace				15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eliza Trent									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 213-07-5264		17. INFORMANT ADDRESS Susie M Wallace 1701 Eutaw Pl.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio pulmonary failure 7070 DUE TO, OR AS A CONSEQUENCE OF (b) sepsis DUE TO, OR AS A CONSEQUENCE OF (c) deep, extensive pressure sores one week 3 months										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): multiple cerebrovascular accidents													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 9-15, 19 82, to 10-27 19 82, that (I) (we) last saw the deceased alive on 10-26 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE R. Bottwell				DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-27-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11/3/82		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Arbutus MD.					
24. FUNERAL DIRECTOR NAME Wm C March F/H, Inc.						ADDRESS 1101 E. North Ave.		25a. DATE REC'D. BY REGISTRAR OCT 28 1982					
25b. REGISTRAR'S SIGNATURE John J. Smith													

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked for, item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 3 2 5 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) MARVIN D WALLACE						2a. DATE OF DEATH MONTH DAY YEAR 10 14 82				2b. HOUR 7:50AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 4 27 15		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore city MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Collections			12b. KIND OF BUSINESS OR INDUSTRY B G & E				
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Catonsville		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2021 Cedar Circle Dr. 21228			
14. FATHER'S NAME FIRST MIDDLE LAST William Wallace						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Rebecca unknown							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 240-05-4214		17. INFORMANT ADDRESS Irene S. Wallace, 2021 Cedar Circle Dr. 21228									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory arrest DUE TO, OR AS A CONSEQUENCE OF (b) Stage IV Cancer of Blung DUE TO, OR AS A CONSEQUENCE OF (c) Left cerebrovascular accident with Right hemiplegia										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1629			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.													
22b. SIGNATURE Qui D. Huynh						DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Qui D. Huynh						22e. ADDRESS St. Agnes Hospital, Balto.Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/16/82		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.				23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland					
24. FUNERAL DIRECTOR NAME 1630 Edmondson Ave., Catonsville Md Witzke Catonsville Funeral Home, P.A. 21228						25a. DATE REC'D. BY REGISTRAR OCT 15 1982		25b. REGISTRAR'S SIGNATURE John J. Carver					

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[unclear] G. H. [unclear]

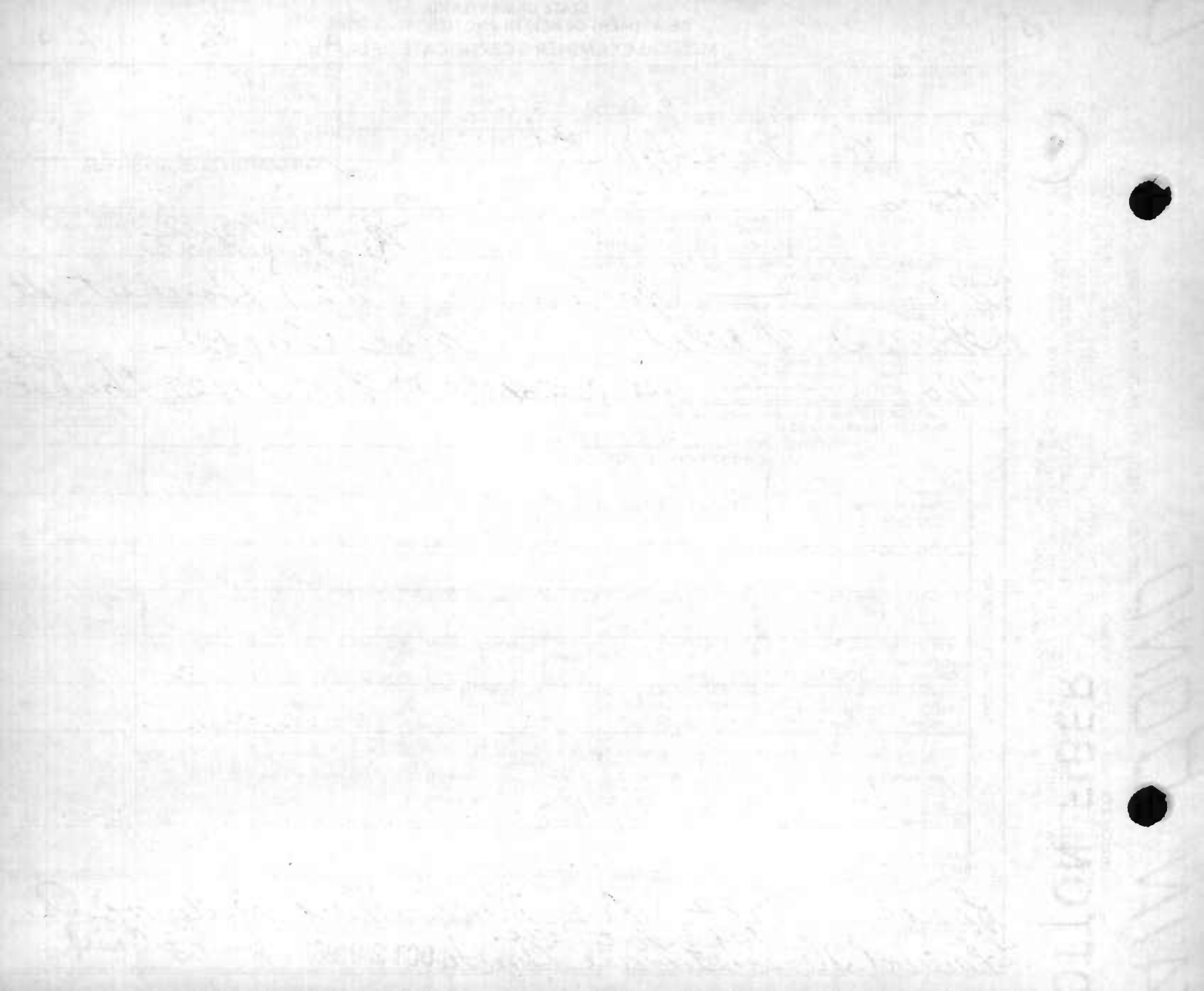
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH PAGES 3, 4, AND 5, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										2 6 3 2 6 REG. NO.	
1- FOR STATE REGISTRAR			2a. DECEASED NAME (TYPE OR PRINT)			FIRST MIDDLE LAST			2b. DATE KNOWN OF DEATH		
			Rodney S. Walls						XX MONTH DAY YEAR HOUR		
3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)		
M			W			March 27 1962			20 YRS. MONTHS DAYS		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)			8. MARRIED			9. DATE PRONOUNCED DEAD			10. BALTIMORE CITY OR COUNTY OF DEATH		
Adams Rd.			WIDOWED			10 27 19 82			Baltimore City, MD		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION			12. USUAL OCCUPATION, TYPE OF WORK			13. KIND OF BUSINESS OR INDUSTRY		
Baltimore			Lawrence & Fort Avenues			Nursing Home					
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		
Charles Hall			Carol Clapper			No			315-90-538		
17. INFORMANT			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		
Mr. F. Hall			PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple Injuries								
			(b) 8122								
			(c)								
			PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
20a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH			20b. TIME OF INJURY			20c. HOW INJURY OCCURRED			20. AUTOPSY?		
X			10:50 M. 10 27 1982			Cyclist impacted tractor-trailer			YES (X) NO		
21a. INJURY OCCURRED			21b. PLACE OF INJURY			21c. LOCATION			22. I certify that I took charge of the remains described above, held on		
WHILE AT WORK			road			Lawrence & Fort Aves., Balto., Md.			Autopsy (X) Inspection Inquiry and in my opinion		
22a. I certify that I took charge of the remains described above, held on			22b. DATE			22c. NAME OF CEMETERY OR CREMATORY			22d. DATE REC'D. BY REGISTRAR		
death resulted from			4/1/82			Blow Memorial Park, Bellwood Co.			OCT 29 1982		
Natural causes			Accident (X)			Suicide			Homicide		
Undetermined manner											
ACTUAL SIGNATURE			EXAMINER'S NAME			TITLE (SPECIFY)			DATE SIGNED		
Dennis F. Smyth, M.D.			Dennis F. Smyth, M.D.			Assistant			10-28-82		
23a. BURIAL, CREMATION, REMOVAL			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY			23d. DATE REC'D. BY REGISTRAR		
Burial			4/1/82			Blow Memorial Park, Bellwood Co.			OCT 29 1982		
24. FUNERAL DIRECTOR			24b. DATE			24c. NAME OF CEMETERY OR CREMATORY			24d. DATE REC'D. BY REGISTRAR		
Charles L. Stevens			154 E. Fort Ave.			Blow Memorial Park, Bellwood Co.			OCT 29 1982		

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

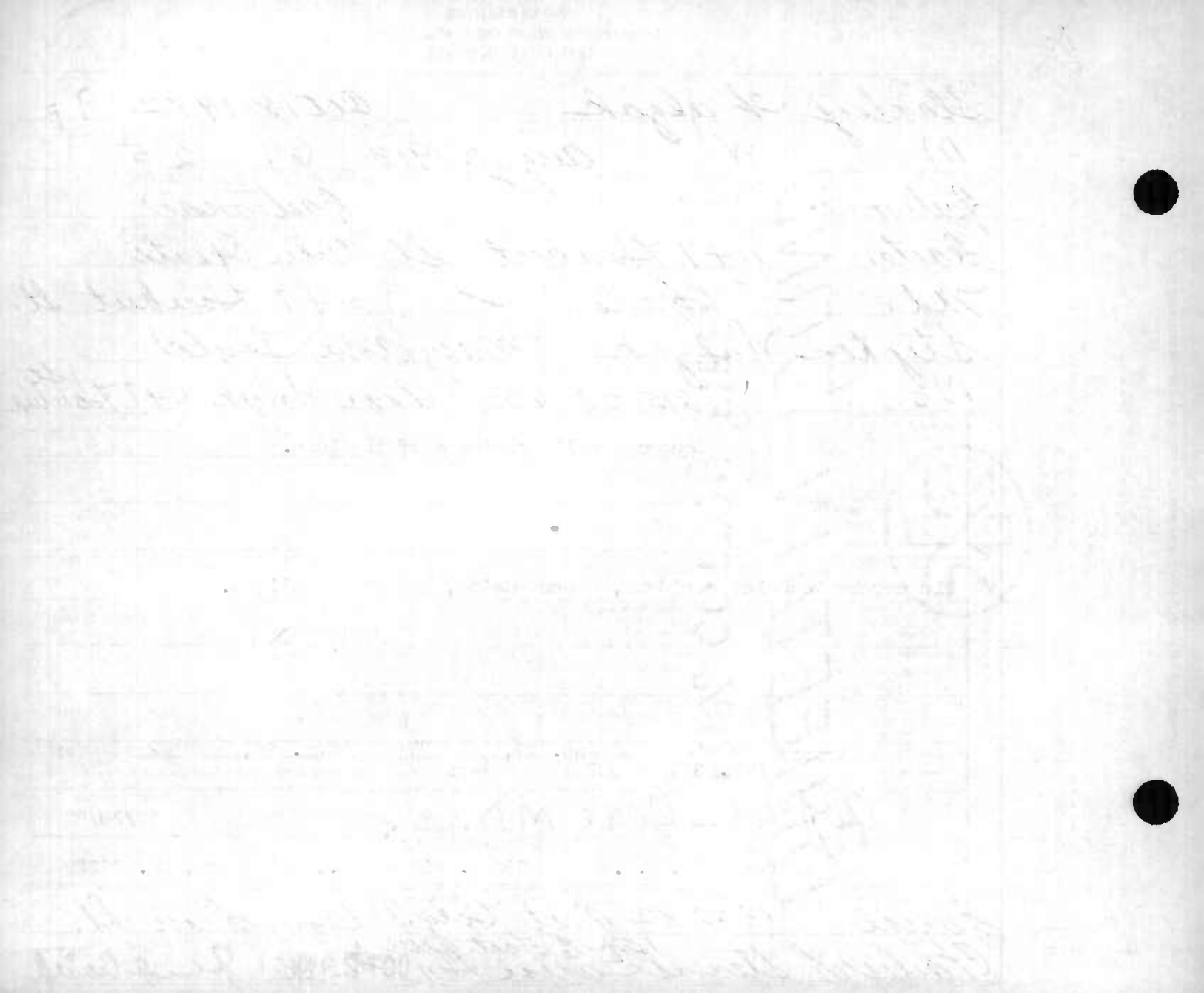


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be called by a physician.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 3 2 1 REG. NO.	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) <i>Stanley Walzak</i>					2a. DATE OF DEATH MONTH DAY YEAR <i>Oct 18, 1982</i>				2b. HOUR 9 P.M.		
3. SEX <i>M</i>		4. RACE <i>W</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>Aug. 13, 1913</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>69</i> YRS		7. IF UNDER 1 YEAR MONTHS DAYS <i>2 5</i>		8. IF UNDER 24 HRS. HOURS MIN.	
9. BIRTHPLACE (STATE OR FOREIGN) <i>Baltimore</i>		10. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		12. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore</i> MD.					
13. CITY OR TOWN OF DEATH <i>Baltimore</i>		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>1147 Lombard St. St. Martin's Hospital</i>				15. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Operator</i>			16. KIND OF BUSINESS OR INDUSTRY		
17. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) <i>Md.</i>				18. COUNTY <i>Baltimore</i>		19. CITY OR TOWN <i>Baltimore</i>		20. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		21. STREET ADDRESS <i>1147 Lombard St.</i>	
22. FATHER'S NAME <i>Stephen Walzak</i>				23. MOTHER'S MAIDEN NAME <i>Mary Ann Loyd</i>							
24. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, GIVE WAR OR DATES) <i>No.</i>				25. SOCIAL SECURITY NO. <i>215-03-6331</i>		26. INFORMANT ADDRESS <i>Anna Walzak 1147 Lombard St.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Squamous cell carcinoma of the lung.</i> <i>1629</i> DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Old cerebrovascular accident, Hypertension, Diabetes Mellitus.</i>											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (we) attended the deceased from <i>Jan. 27, 1977</i> to <i>Oct. 18, 1982</i> , that (I) (we) last saw the deceased alive on <i>Oct. 18, 1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Alfred Cole</i>				22c. DEGREE <i>M.D.</i>				22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22e. DATE SIGNED <i>10/20/82</i>	
22f. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Alfred Cole, M.D.</i>				22g. ADDRESS <i>136 S. Hilton St., Baltimore, Md. 21229</i>							
23a. BURIAL, CREMATION, REMOVAL <i>Burial</i>				23b. DATE <i>10/23/82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Mount Holy Redeemer Church Rd.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR <i>Charles S. Stevens</i>				25. DAY REC'D. BY REGISTRAR <i>Oct 20 1982</i>				26. REGISTRAR'S SIGNATURE <i>John J. Givens</i>			



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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

FOR STATE REGISTRAR		STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 2 6 3 2 8 REG. NO.	
1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST GEORGE S. WARFIELD		2a. DATE OF DEATH MONTH DAY YEAR 10 7 82	
3. SEX M		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 10 06 18	
6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7b. CITIZEN OF WHAT COUNTRY? USA		7a. HOUR 10:55 AM	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALT. CITY MD	
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Univ. Md. Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed Driver	
12b. KIND OF BUSINESS OR INDUSTRY Moving Co.		13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD		13b. COUNTY BALT.	
13c. CITY OR TOWN BALT.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1517 Edmonson AVE	
14. FATHER'S NAME FIRST MIDDLE LAST UNKNOWN Augustus Warfield		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST UNKNOWN Elizabeth Wilkens			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) UNKNOWN Yes - WWII		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-05-9588 UNKNOWN		17. INFORMANT ADDRESS HOSPITAL CHART	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 cardiac arrest. DUE TO, OR AS A CONSEQUENCE OF (b) renal failure. DUE TO, OR AS A CONSEQUENCE OF (c) Spleen CA lump.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION 4/20/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Squamous cell cancer lung		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY, IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			
21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (this hospital) attended the deceased from 9/14, 19 82, to 10/7, 19 82, that (we) last saw the deceased alive on 10/7/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Beebe		DEGREE MD		22c. DATE SIGNED 10/7/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) BADRLES		22e. ADDRESS Univ. Md. Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Removal		23b. DATE 10/7/82		23c. NAME OF CEMETERY OR CREMATORY	
23d. LOCATION CITY OR TOWN COUNTY STATE					
24. FUNERAL DIRECTOR NAME Anatomy Board		ADDRESS Balto., Md.		25a. DATE REC'D. BY REGISTRAR OCT 18 1982	
25b. REGISTRAR'S SIGNATURE John J. Conner					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

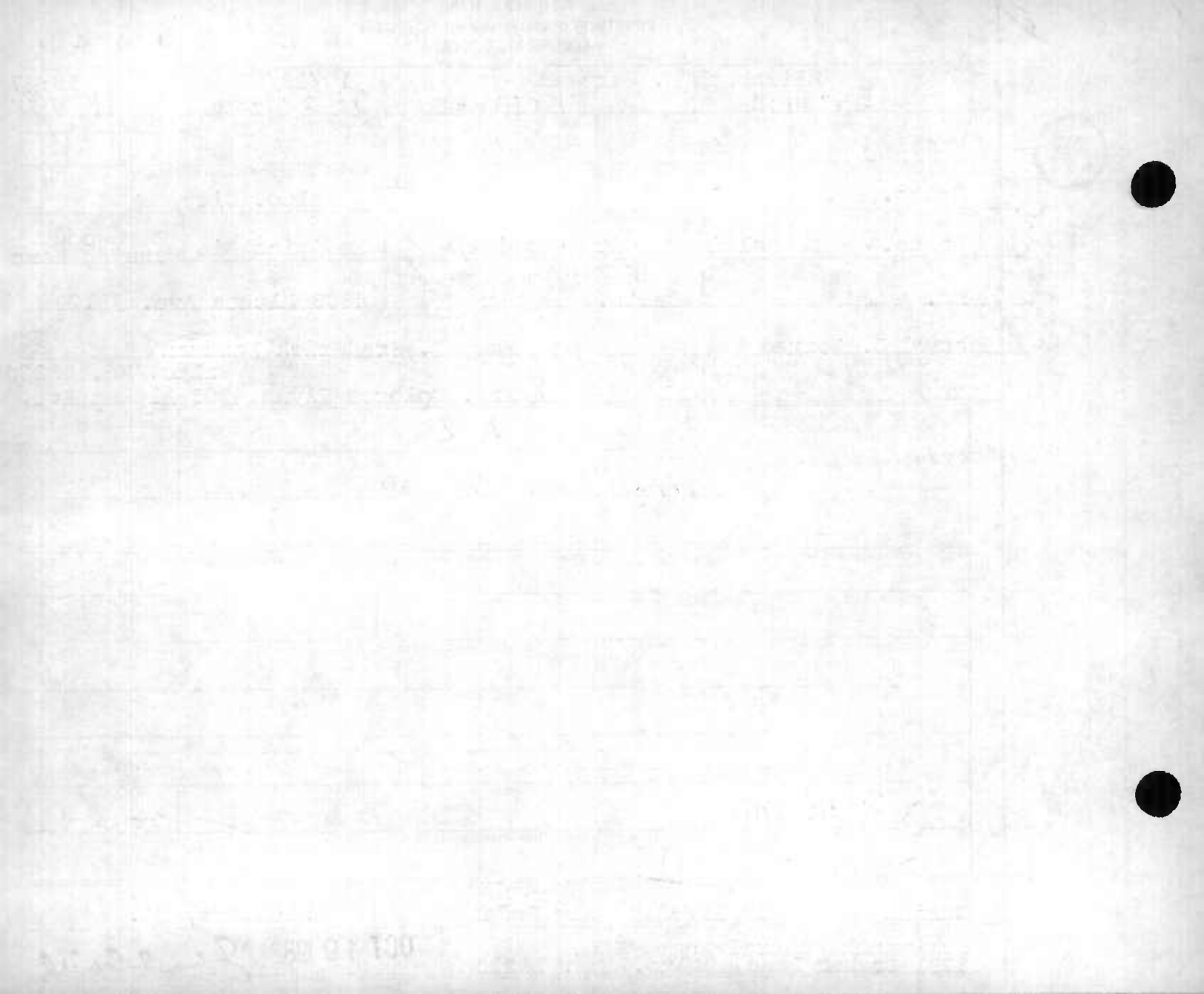
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 2 9
REG. NO.

1 DECEASED NAME (TYPE OR PRINT) Elizabeth M. Wartman		2a DATE OF DEATH 10/12/82 Oct 12 - 1982		2b HOUR 10:47 AM	
3 SEX Female	4 RACE White	5 DATE OF BIRTH 5/5/51		6 AGE (IN YEARS LAST BIRTHDAY) 31 YRS	
7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.	7b CITIZEN OF WHAT COUNTRY? USA	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10 CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital		12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Medicine Aid		12b KIND OF BUSINESS OR INDUSTRY Edgewood Nursing Home
13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a STATE Md.	13b COUNTY -	13c CITY OR TOWN Balto.	13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
14 FATHER'S NAME FIRST MIDDLE LAST Edward J. Conrad		15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary E. Frederick			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b SOCIAL SECURITY NO. - -		17 INFORMANT ADDRESS Balto, Md. 21206	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiogenic Shock</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arrhythmocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____					
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f LOCATION STREET CITY OR TOWN COUNTY STATE	
22a I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE R. Fintel MD		DEGREE		22c DATE SIGNED Oct 12 - 82	
22d PHYSICIAN'S NAME (TYPE OR PRINT) R. Fintel MD		22e ADDRESS			
23a BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b DATE 10/15/82		23c NAME OF CEMETERY OR CREMATORY Holy Redeemer	
23d LOCATION CITY OR TOWN COUNTY STATE Baltimore, Md.		23e DATE REC'D BY REGISTRAR OCT 19 1982			
24 FUNERAL DIRECTOR Schimunek Funeral Home, Inc. 3331 Brehms Lane, Balto., Md. 21213		25 REGISTRAR'S SIGNATURE John J. Caniff			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 3 0

REG. NO.

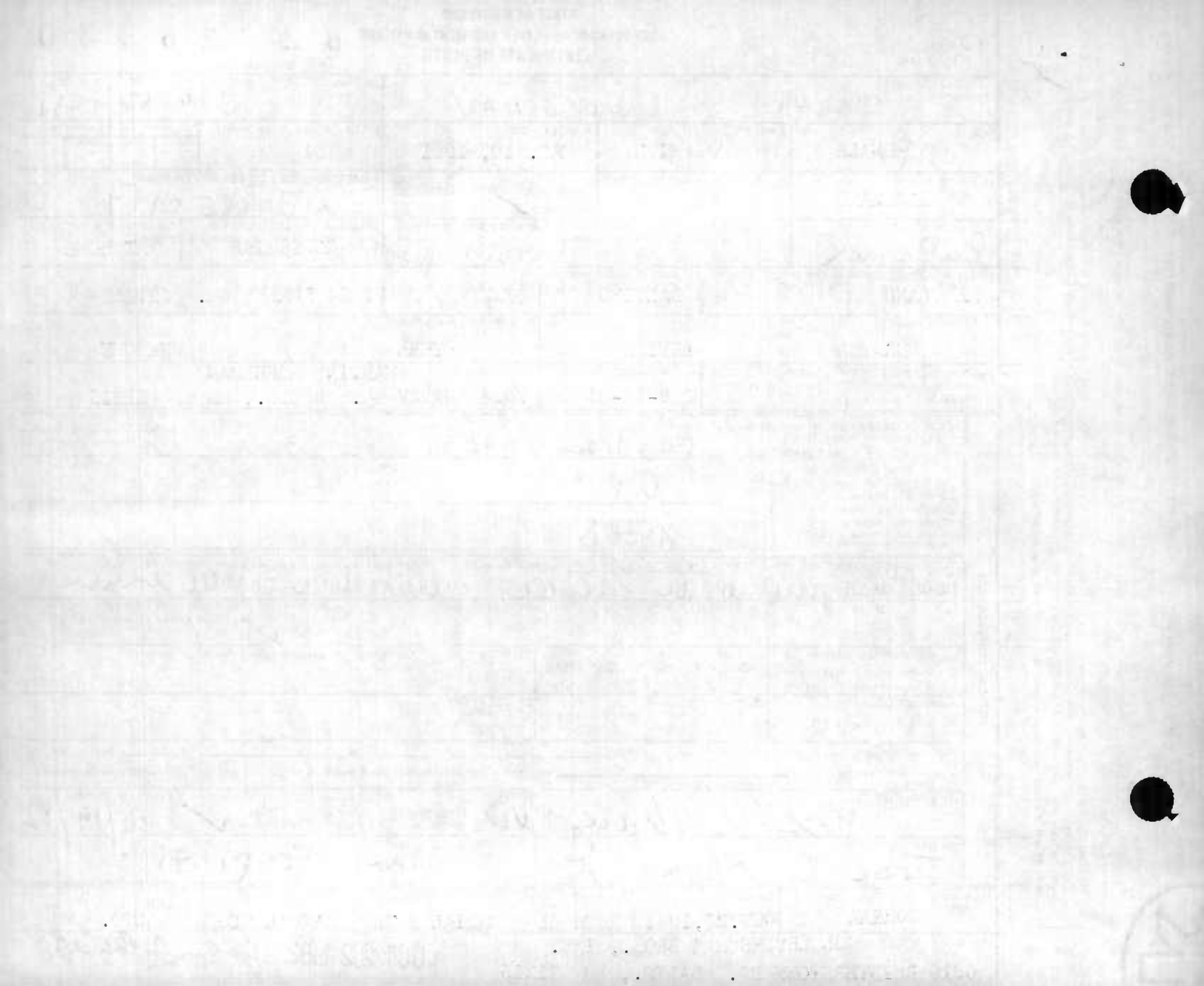
1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) SARAH WASSERMAN			2a. DATE OF DEATH MONTH DAY YEAR 10 19 82			2b. HOUR 1:45 am	
3. SEX FEMALE		4. RACE WHITE		5. DATE OF BIRTH MAR. 10 th , 1901 st		6. AGE (IN YEARS LAST BIRTHDAY) 81	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sara's Hosp. Inc.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE	
12b. KIND OF BUSINESS OR INDUSTRY AT HOME							
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND				13b. COUNTY BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MORDICA MIDDLE LAST LEVINE				15. MOTHER'S MAIDEN NAME FIRST ETHEL MIDDLE LAST UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 218-18-0363D		17. INFORMANT MARTIN WASSERMAN		7054 SURREY DR. BALTO., MD 21215	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest.</u> 4100 DUE TO, OR AS A CONSEQUENCE OF (b) <u>MI</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>ASCVD.</u> DUE TO, OR AS A CONSEQUENCE OF PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Renal failure pulmonary embolism, ventricular arrhythmia</u>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Jose R. Alvarez MD</u>		22c. DATE SIGNED 10/19/82				22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jose R. Alvarez MD	
22e. ADDRESS SINAI Hospital		22f. DATE REC'D. BY REGISTRAR OCT 22 1982					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE OCT. 20, 1982		23c. NAME OF CEMETERY OR CREMATORY BETH EL MEMORIAL PARK		23d. LOCATION CITY OR TOWN COUNTY STATE RANDALLSTOWN BALTO. MD	
24. FUNERAL DIRECTOR NAME SOL LEVINSON & BROS., INC. ADDRESS 6010 REISTERSTOWN RD. BALTO., MD 21215				25. DATE REC'D. BY REGISTRAR OCT 22 1982			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH				2b. HOUR							
FIRST MIDDLE LAST				MONTH DAY YEAR				MONTH DAY YEAR							
ADA MAY WATERS				10 21 82				6:24 P.M.							
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE		7. IF UNDER 1 YEAR		7. IF UNDER 24 HRS					
FEMALE		BLACK		9 13 10		65 YRS.		MONTHS DAYS		HOURS MIN.					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH									
MARYLAND						BALTIMORE CITY MD.									
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION				12a. USUAL OCCUPATION				12b. KIND OF BUSINESS OR INDUSTRY					
BALTIMORE		SINAI HOSPITAL				STOCK CLERK				STEWARTS					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. COUNTY				13c. INSIDE CITY LIMITS?				13d. STREET ADDRESS			
MARYLAND				BALTIMORE				YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				3717 W. BELVEDERE AVE. BALTIMORE, MARYLAND 21215			
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME				16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.			
ANDREW				BEALE				NO				212-22-3577			
17. INFORMANT				18. CAUSE OF DEATH				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
BALTIMORE, MARYLAND 21215				18a. IMMEDIATE CAUSE (a)				8 hrs							
Mr. Heisler V. WATERS 3717 W. Belvedere Ave.				18b. DUE TO, OR AS A CONSEQUENCE OF				1 Days							
				18c. DUE TO, OR AS A CONSEQUENCE OF				weeks							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
								YES <input type="checkbox"/> NO <input type="checkbox"/>				YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
				HOUR A.M. MONTH DAY YEAR											
21d. INJURY OCCURRED				21e. PLACE OF INJURY				21f. LOCATION							
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (1) (this hospital) attended the deceased from 10/21/82 to 10/21/82, that (1) (we) lost saw the deceased alive on 10/21/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (and) (did not) view the body after death.												22c. DATE SIGNED			
22b. SIGNATURE												10/21/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)												22e. ADDRESS			
Louis W. Miller MD												6804 North Height			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				10/25/82				Deer Park Memorial Gardens, Finksburg, Maryland				CITY OR TOWN COUNTY STATE			
24. FUNERAL DIRECTOR				25a. DATE REC'D. BY REGISTRAR				25b. DATE REC'D. BY REGISTRAR							
Herbert E. Nutter Funeral Home				3035 W. NORTH AVE.				OCT 26 1982							

27175



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225000 1000 430

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10-1-10

Handwritten notes and calculations, including the word "Amount" and various numbers.



20%

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 6 3 3 2			
Items 4 Phone 11-17-82				CERTIFICATE OF DEATH				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY HELEN WATERS				2a. DATE OF DEATH MONTH DAY YEAR 10 31 82				2b. HOUR M			
3. SEX female		4. RACE USA Black		5. DATE OF BIRTH MONTH DAY YEAR 12 2 1888		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.					
10. CITY OR TOWN OF DEATH Balto.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) CHAPEL HILL CONVELESCENT HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MD.				13b. COUNTY		13c. BALTO. TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 3354 Dolfield Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Robert Davis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Eliz Grinnell							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no				16b. SOCIAL SECURITY NO. 214-40-8317-J		17. INFORMANT ADDRESS Lols White 3354 Dolfield Ave.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute coronary failure</u> 4140 DUE TO, OR AS A CONSEQUENCE OF: (b) <u>ASHD, CHF, S.M. type I</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) <u>Old Age (94)</u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (the hospital) attended the deceased from <u>4-9</u> , 19 <u>82</u> , to <u>10-31</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>10-26</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.											
22b. SIGNATURE <u>Kenzo Ricci MD</u> DEGREE								22c. DATE SIGNED 11-2-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KENZO RICCI, MD								22e. ADDRESS 2893 BALTO. BLVD. FINKSBURG, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 11/4/82		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.			
24. FUNERAL DIRECTOR NAME Leroy O. Dyett 4600 LIBERTY HIGTS. AVE.						25a. DATE REC'D. BY REGISTRAR NOV 3 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 48 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 6 3 3 3			
1. DECEASED NAME (TYPE OR PRINT) Watkins				REG. NO.			
2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR		MIN	
10/23/82				7:40		A M	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS LAST BIRTHDAY)				
MALE	WHITE	2 27 26	56 YRS.				
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH				
MARYLAND	U.S.A.		BALTIMORE CITY MD.				
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	12b. KIND OF BUSINESS OR INDUSTRY				
BALTIMORE	Pimlico MANOR	DRIVER	OIL Co.				
13a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13b. STREET ADDRESS					
		1408 STOCKTON ROAD					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME					
CHARLES L. WATKINS SR.		FLORENCE BENNETT					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
YES		217-12-9358		FAMILY RECORDS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY:							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
IMMEDIATE CAUSE (a) M.I.							acute
4100							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							
DUE TO, OR AS A CONSEQUENCE OF							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		P.M. 19					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10-15</u> , 19 <u>82</u> , to <u>10-23</u> , 19 <u>82</u> , that (I) (we) lost saw the deceased alive on <u>10-22</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
<i>[Signature]</i>						10/25/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
Dr. L.A. Kochman				10 Stonehenge Circle 21208			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE	
BURIAL		10-26-1982		CROWNSVILLE VET.		CROWNSVILLE MARYLAND	
24. FUNERAL DIRECTOR NAME				25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE			
EVANS FUNERAL CHAPEL 8800 HARFORD				NOV 1 1982 <i>[Signature]</i>			

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The following is a list of the
names of the persons who
were present at the
meeting of the
Board of Directors
of the
Company held on
the 10th day of
January, 1914.
The names of the
persons who were
present are as
follows:

Name	Address
John A. Smith	123 Main St., New York
James B. Jones	456 Broadway, New York
William C. Brown	789 Fifth Ave., New York
Robert D. White	1010 Third Ave., New York
Charles E. Black	1111 Second Ave., New York
Frank G. Green	1212 First Ave., New York
George H. Hall	1313 West 125th St., New York
Harold I. King	1414 East 125th St., New York
Arthur J. Lee	1515 Central Ave., New York
Edmund K. Miller	1616 Central Ave., New York
John L. Davis	1717 Central Ave., New York
William M. Wilson	1818 Central Ave., New York
Charles N. Taylor	1919 Central Ave., New York
George O. Scott	2020 Central Ave., New York
Harold P. Adams	2121 Central Ave., New York
Arthur Q. Baker	2222 Central Ave., New York
Edmund R. Clark	2323 Central Ave., New York
John S. Evans	2424 Central Ave., New York
William T. Foster	2525 Central Ave., New York
Charles U. Gibson	2626 Central Ave., New York
George V. Hill	2727 Central Ave., New York
Harold W. Young	2828 Central Ave., New York
Arthur X. Allen	2929 Central Ave., New York
Edmund Y. Wright	3030 Central Ave., New York
John Z. Baker	3131 Central Ave., New York
William A. Clark	3232 Central Ave., New York
Charles B. Evans	3333 Central Ave., New York
George C. Foster	3434 Central Ave., New York
Harold D. Gibson	3535 Central Ave., New York
Arthur E. Hill	3636 Central Ave., New York
Edmund F. Young	3737 Central Ave., New York
John G. Allen	3838 Central Ave., New York
William H. Wright	3939 Central Ave., New York
Charles I. Baker	4040 Central Ave., New York
George J. Clark	4141 Central Ave., New York
Harold K. Evans	4242 Central Ave., New York
Arthur L. Foster	4343 Central Ave., New York
Edmund M. Gibson	4444 Central Ave., New York
John N. Hill	4545 Central Ave., New York
William O. Young	4646 Central Ave., New York
Charles P. Allen	4747 Central Ave., New York
George Q. Wright	4848 Central Ave., New York
Harold R. Baker	4949 Central Ave., New York
Arthur S. Clark	5050 Central Ave., New York
Edmund T. Evans	5151 Central Ave., New York
John U. Foster	5252 Central Ave., New York
William V. Gibson	5353 Central Ave., New York
Charles W. Hill	5454 Central Ave., New York
George X. Young	5555 Central Ave., New York
Harold Y. Allen	5656 Central Ave., New York
Arthur Z. Wright	5757 Central Ave., New York
Edmund A. Baker	5858 Central Ave., New York
John B. Clark	5959 Central Ave., New York
William C. Evans	6060 Central Ave., New York
Charles D. Foster	6161 Central Ave., New York
George E. Gibson	6262 Central Ave., New York
Harold F. Hill	6363 Central Ave., New York
Arthur G. Young	6464 Central Ave., New York
Edmund H. Allen	6565 Central Ave., New York
John I. Wright	6666 Central Ave., New York
William J. Baker	6767 Central Ave., New York
Charles K. Clark	6868 Central Ave., New York
George L. Evans	6969 Central Ave., New York
Harold M. Foster	7070 Central Ave., New York
Arthur N. Gibson	7171 Central Ave., New York
Edmund O. Hill	7272 Central Ave., New York
John P. Young	7373 Central Ave., New York
William Q. Allen	7474 Central Ave., New York
Charles R. Wright	7575 Central Ave., New York
George S. Baker	7676 Central Ave., New York
Harold T. Clark	7777 Central Ave., New York
Arthur U. Evans	7878 Central Ave., New York
Edmund V. Foster	7979 Central Ave., New York
John W. Gibson	8080 Central Ave., New York
William X. Hill	8181 Central Ave., New York
Charles Y. Young	8282 Central Ave., New York
George Z. Allen	8383 Central Ave., New York
Harold A. Wright	8484 Central Ave., New York
Arthur B. Baker	8585 Central Ave., New York
Edmund C. Clark	8686 Central Ave., New York
John D. Evans	8787 Central Ave., New York
William E. Foster	8888 Central Ave., New York
Charles F. Gibson	8989 Central Ave., New York
George G. Hill	9090 Central Ave., New York
Harold H. Young	9191 Central Ave., New York
Arthur I. Allen	9292 Central Ave., New York
Edmund J. Wright	9393 Central Ave., New York
John K. Baker	9494 Central Ave., New York
William L. Clark	9595 Central Ave., New York
Charles M. Evans	9696 Central Ave., New York
George N. Foster	9797 Central Ave., New York
Harold O. Gibson	9898 Central Ave., New York
Arthur P. Hill	9999 Central Ave., New York

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with 122 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 6 3 3 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WALTER L. WATKINS Sr.				2a. DATE OF DEATH MONTH DAY YEAR 10 25 82			
3. SEX M Male				4. RACE W White		5. DATE OF BIRTH MONTH DAY YEAR 1 15 20	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY) 62 YRS.	
9. BALTIMORE CITY OR COUNTY OF DEATH CITY MD.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Machinist			
10. CITY OR TOWN OF DEATH BALTIMORE				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNIV. OF MARYLAND HOSPITAL			
12b. KIND OF BUSINESS OR INDUSTRY				12c. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)			
13a. STATE MARYLAND		13b. COUNTY BALTIMORE		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST FIELDING L. WATKINS Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Blanche Hayes			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) / (IF YES, GIVE WAR OR DATES) No				16b. SOCIAL SECURITY NO. 215-14-8417		17. INFORMANT ADDRESS Doris V. Watkins 701 Fuselage Ave.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1539 IMMEDIATE CAUSE (a) METASTASTIC COLON CARCINOMA DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 16							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 04.25.82 to Oct. 25.82, that (I) (we) last saw the deceased alive on above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE So, and				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/25/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) So				22e. ADDRESS 22 S GREENE ST. BALTO. MD. 21201			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct 28 1982		23c. NAME OF CEMETERY OR CREMATORY Moreland Memorial		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland				25. DATE REC'D. BY REGISTRAR OCT 27 1982			
				26. REGISTRAR'S SIGNATURE John J. Conner			

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1994, 1995, 1996, 1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 26

THE UNIVERSITY OF CHICAGO

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 6 3 3 5 REG. NO.			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA E. WATSON			
2. SEX FEMALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 06-05-08		2a. DATE OF DEATH MONTH DAY YEAR 10 - 9-82 2b. HOUR 2:10 PM	
3. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 72 HRS. HOURS MIN.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John L. DEATON MEDICAL		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House-wife	
13a. STATE Maryland		13b. COUNTY - -		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 514 S. Collington Ave.	
14. FATHER'S NAME FIRST MIDDLE LAST Joseph Weisener				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Carrie - BROWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. 215-09-6346		17. INFORMANT ADDRESS Edward J. Sapp 219 N. Luzerne Ave.			
18. CAUSE OF DEATH (Enter only one cause, but give for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pulmonary embolus DUE TO, OR AS A CONSEQUENCE OF (b) CVA & hemiparesis & coma DUE TO, OR AS A CONSEQUENCE OF (c) Diabetes mellitus 4360 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: no							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22. I certify that (I) (this hospital) attended the deceased from Aug 10 19 78 to Oct 9 19 82 that (I) (we) last saw the deceased alive on Oct 7 19 82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22a. SIGNATURE Julian W. Reed				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/11/82	
22b. PHYSICIAN'S NAME (TYPE OR PRINT) JULIAN W. REED M.D.				22d. ADDRESS 615 S. CHAS. ST. BALTO, MD. 21230			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 12, 82		23c. NAME OF CEMETERY OR CREMATORY Holy Redeemer Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, - , Maryland	
24. FUNERAL DIRECTOR NAME Lilly & Zeiler Inc. 1901 Eastern Ave.				25a. DATE REC'D. BY REGISTRAR OCT 14 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	

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item 6 #G572 10/19/82 ph

FOR
1 - STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 22069

1. DECEASED NAME (TYPE OR PRINT) HELEN WEBB			7a. DATE OF DEATH MONTH DAY YEAR OCTOBER 09, 1982		7b. HOUR 01:30AM
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 7 29 23		6. AGE (IN YEARS) (LAST BIRTHDAY) 59 -61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Sidney Blount			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bell Carmon		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Isaac Webb 2530 Robb Street	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5715 IMMEDIATE CAUSE (a) Consumptive coagulopathy DUE TO, OR AS A CONSEQUENCE OF (b) Cirrhosis of liver, unknown etiology DUE TO, OR AS A CONSEQUENCE OF (c) CONDITIONS, if any, which gave rise to immediate cause (a), stating the underlying cause last					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION 8/31/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Bleeding esophageal varices		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (1) this hospital attended the deceased from 8/31 , 19 82 , to 10/9 , 19 82 , that (1) <input checked="" type="checkbox"/> last saw the deceased alive on 10/9 , 19 82 , and that in (my) <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above. <input type="checkbox"/> (we) <input type="checkbox"/> (did not) view the body after death.					
22b. SIGNATURE Scott Kaufman		DEGREE M.D., PH.D.		22c. DATE SIGNED 10/9/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Scott Kaufman		22e. ADDRESS 600 N. Wolfe St. Baltimore, Md. 21205			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/14/82		23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cem	
23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville Md.		24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North Avenue			
25a. DATE REC'D. BY REGISTRAR OCT 11 1982		REGISTRAR'S SIGNATURE John J. Carver			

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DATE: 10/1/55 TIME: 1:30 PM

TO: DIRECTOR, FBI

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

1. [Illegible]

2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

6. [Illegible]

7. [Illegible]

8. [Illegible]

9. [Illegible]

10. [Illegible]

11. [Illegible]

12. [Illegible]

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 3 7
REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CARRIE VIRGINIA WEBER			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 12, 1982		2b. HOUR 5:35AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR April 17, 1916		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY, MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Home Maker	12b. KIND OF BUSINESS OR INDUSTRY Own Home
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)					
13a. STATE Maryland	13b. COUNTY Baltimore	13c. CITY OR TOWN Baldwin	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 13821 Baldwin Mill Road 21013	
14. FATHER'S NAME FIRST MIDDLE LAST Clarence Charles Firebaugh			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Armanda Shifflett		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-22-3613		17. INFORMANT ADDRESS Adam H. Weber, Sr. Same as #13.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 2030 IMMEDIATE CAUSE (a) Cardiorespiratory Arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) multiple myeloma		
DUE TO, OR AS A CONSEQUENCE OF (c)		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Hyperbilirubinemia, hypercalcemia		

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE		
22a. I certify that (I) (this hospital) attended the deceased from 8/25 , 19 82 , to 10/12 , 19 82 , that (I) (we) last saw the deceased alive on 10/12 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE Susan B. Bressler	DEGREE MD	ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	22c. DATE SIGNED 10/12/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Susan B. Bressler	22e. ADDRESS John Hopkins Hospital Baltimore Md 21205			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Entombment	23b. DATE Oct. 15, 1982	23c. NAME OF CEMETERY OR CREMATORY Dulaney Valley Mausoleum	23d. LOCATION CITY OR TOWN COUNTY STATE Cockeysville Balto., Md.
24. FUNERAL DIRECTOR NAME Ruck Towson Funeral Home, Inc. Towson, Md. 21204		25a. DATE REC'D. BY REGISTRAR OCT 14 1982	25b. REGISTRAR'S SIGNATURE John J. Connel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

RECEIVED
JAN 10 1967

TO: DIRECTOR, FBI (100-371097) FROM: SAC, NEW YORK (100-100000) (P)

SUBJECT: JAMES EARL RAY, AKA; ALLEGED ATTEMPT TO OBTAIN PASSPORT FOR TRIP TO AFRICA

RE: NEW YORK TELETYPE TO BUREAU, JANUARY 9, 1967.

ADVISE THAT THE NEW YORK OFFICE HAS BEEN ADVISED THAT THE INDIVIDUAL IN QUESTION IS CURRENTLY IN THE COUNTRY OF AFRICA.

THE INDIVIDUAL IN QUESTION IS CURRENTLY IN THE COUNTRY OF AFRICA.

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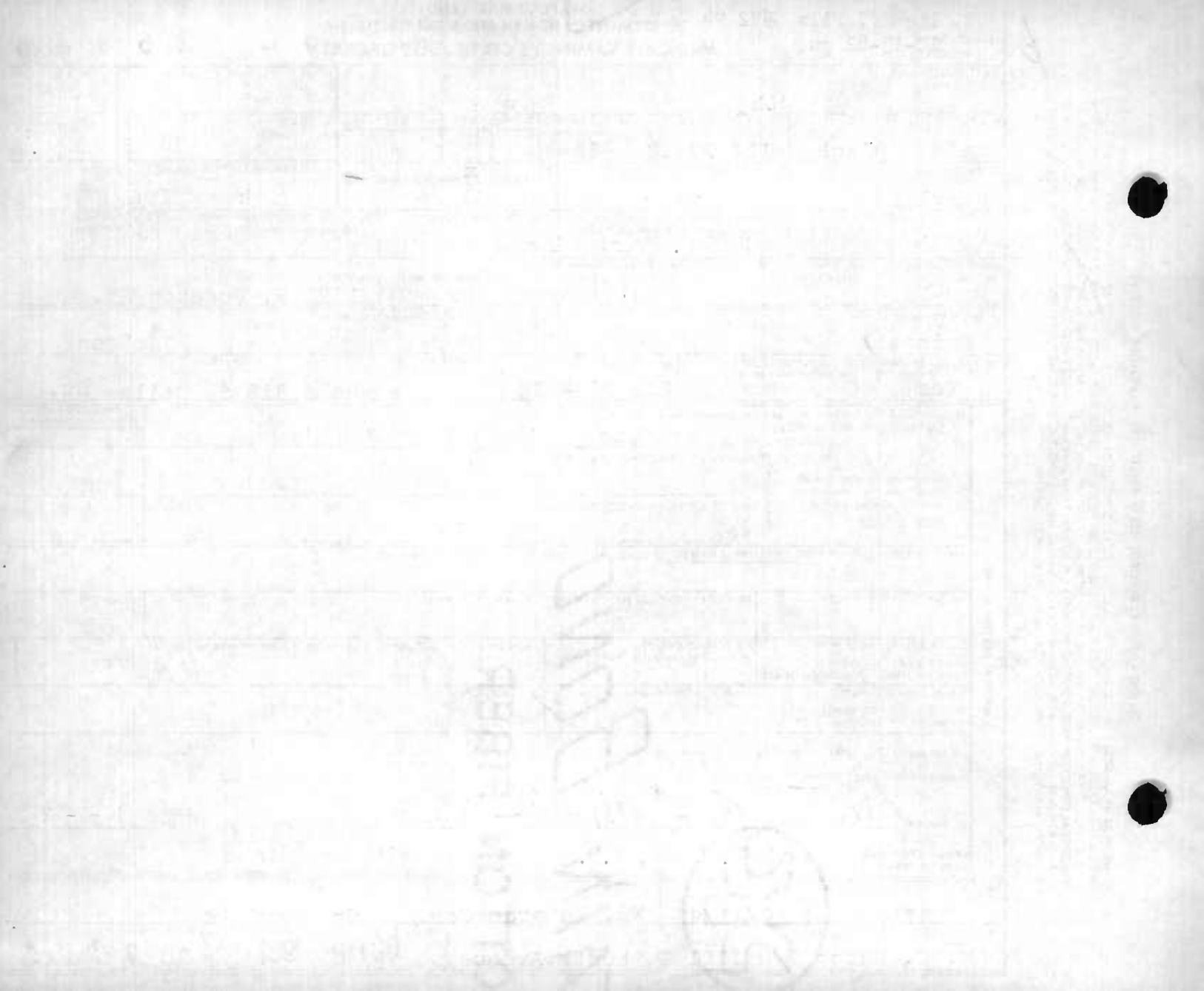
THE INDIVIDUAL IN QUESTION IS CURRENTLY IN THE COUNTRY OF AFRICA.

THE INDIVIDUAL IN QUESTION IS CURRENTLY IN THE COUNTRY OF AFRICA.

THE INDIVIDUAL IN QUESTION IS CURRENTLY IN THE COUNTRY OF AFRICA.

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26338	
1. DECEASED NAME (TYPE OR PRINT) Randolph										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 10 DAY 6 YEAR 1982	
2. SEX male 3. RACE Black 4. DATE OF BIRTH MONTH 12 DAY 23 YEAR 28 5. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. 6. IF UNDER 24 YRS. MONTHS Weeks DAYS Weeks HOURS Weeks MIN Weeks										2b. HOUR M	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland 7b. CITIZEN OF WHAT COUNTRY? USA 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>										2c. DATE PRONOUNCED DEAD 10 6 1982 2d. HOUR 10:52 P. M	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.											
10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1525 E. Preston Street										12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Baltimore City,	
12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE Maryland 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 1525 E. Preston St.											
14. FATHER'S NAME FIRST Frizzell MIDDLE Weeks LAST Jackson 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Jackson LAST Jackson											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) Yes (IF YES, GIVE WAR OR DATES)										16b. SOCIAL SECURITY NO. 220-20-3114	
17. INFORMANT ADDRESS Rosetta Weeks 318 S. Dallas Ct.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (c) 										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Dennis F. Smyth M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER										DATE SIGNED 10-7-82	
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL 23b. DATE 10/11/82 23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cem. 23d. LOCATION CITY OR TOWN Crownsville COUNTY Md STATE Md											
24. FUNERAL DIRECTOR NAME Wm. C. March F/H ADDRESS 1101 E. North Avenue										25a. DATE REC'D. BY REGISTRAR OCT 8 1982 25b. REGISTRAR'S SIGNATURE John J. Carver	



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 3 9
REG. NO.

4 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Francis J. Weik</i>		2a. DATE OF DEATH MONTH DAY YEAR <i>10 5 82</i>		2b. HOUR <i>1:43 AM</i>	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>3 19 96</i>	
6. AGE (IN YEARS LAST BIRTHDAY) <i>86</i>		7. IF UNDER 1 YEAR MONTHS DAYS <i>0 0</i>		8. IF UNDER 24 HRS. HOURS MIN. <i>0 0</i>	
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Maryland</i>		10. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		11. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	
12. CITY OR TOWN OF DEATH <i>Baltimore</i>		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (DO NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Bon Secours Hospital</i>		14. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore</i> MD.	
15. USUAL RESIDENCE (IF RESIDING IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) IN STATE IN COUNTY <i>MD Baltimore</i>		16. CITY OF DEATH <i>Woodlawn</i>		17. INSURE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
18. STREET ADDRESS <i>32673 West Park Drive</i>		19. CITY OF DEATH <i>21207</i>		20. STREET ADDRESS <i>21207</i>	
21. FATHER'S NAME FIRST MIDDLE LAST <i>William Weik</i>		22. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Megdalena Unknown</i>		23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i>	
24. SOCIAL SECURITY NO. <i>213-10-2531</i>		25. INFORMANT <i>Mrs. Marjorie Miller</i>		26. ADDRESS <i>5102 Beaverbrook Road Columbia, MD. 21044</i>	
27. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY. <i>4280 IMMEDIATE CAUSE (a) CARDIOPULMONARY ARREST.</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>DECOMPENSATED CONGESTIVE HEART FAILURE</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>ABDOMINAL AORTIC ANEURYSM.</i>					
28. PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) <i>ABDOMINAL AORTIC ANEURYSM.</i>					
29a. DATE OF OPERATION <i>NA</i>		29b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>NA</i>		29c. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
29d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		30a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <i>NA</i>		30b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>NA 19</i>	
30c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) <i>NA</i>		30d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) <i>NA</i>		30e. LOCATION STREET CITY OR TOWN COUNTY STATE <i>NA NA NA NA</i>	
31. I certify that (I) (this hospital) attended the deceased from <i>9-24-1982</i> to <i>10-5-1982</i> , that (I) (we) lost saw the deceased alive on <i>10-4-1982</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
32a. SIGNATURE <i>Surgeon General</i>		32b. DEGREE <i>MD</i>		32c. DATE SIGNED <i>10-5-82</i>	
32d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>SURGIT JULKA</i>		32e. ADDRESS <i>BON SECOURS HOSPITAL</i>		32f. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>	
33a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		33b. DATE <i>10-8-82</i>		33c. NAME OF CEMETERY OR CREMATORY <i>Lorraine Park Cem.</i>	
33d. LOCATION CITY OR TOWN COUNTY STATE <i>Woodlawn Baltimore Maryland</i>		33e. FUNERAL DIRECTOR NAME ADDRESS <i>Loring Byers Funeral Directors, Inc. 8728 Liberty Road Randallstown, MD. 21133</i>		33f. DATE REC'D. BY REGISTRAR <i>OCT 5 1982</i>	
33g. REGISTRAR'S SIGNATURE <i>John J. Connel</i>		33h. REGISTRAR'S SIGNATURE			

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 4 0

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Clementine M. Weinman			2a. DATE OF DEATH MONTH DAY YEAR October 17, 1982		2b. HOUR A. M. A. M.		
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Oct. 26, 1902		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 79	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore, Md.		7b. CITIZEN OF WHAT COUNTRY? U. S. A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Baltimore City Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mach. Operator		12b. KIND OF BUSINESS OR INDUSTRY Parker & Kalen Co. Indus. Mfg.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST John Henderson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Theresa Geebauer		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 212-03-6406	
17. INFORMANT Raymond Weinman		18. ADDRESS Baltimore, Md. 21205		19. STREET ADDRESS 502 N. Highland Avenue		20. CITY OR TOWN Baltimore	

11. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Coronary Artery**

4019

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Hypertension**

DUE TO, OR AS A CONSEQUENCE OF

(c)

APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH

3

year

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from Jan 28 , 19 81 , to Oct 17 , 19 81 , that (I) (we) last saw the deceased alive on August 1 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Jason H. Gaskel M.D.				DEGREE M.D.		22c. DATE SIGNED Oct. 17/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Jason H. Gaskel M.D.				22e. ADDRESS 637 S. Ginkling St. Baltimore Md			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/20/82		23c. NAME OF CEMETERY OR CREMATORY Schwartz Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
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24. FUNERAL DIRECTOR NAME John A. Moran, Inc.		25a. DATE REC'D BY REGISTRAR OCT 19 1982		25b. REGISTRAR'S SIGNATURE [Signature]	
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
1- FOR STATE REGISTRAR					8 2 2 6 3 4 1 REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Charles Elliott Wells					2a. DATE OF DEATH MONTH DAY YEAR Oct. 29, 1982			2b. HOUR 7:55 pm	
3. SEX Male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Nov. 7, 1902		6. AGE (IN YEARS LAST BIRTHDAY) 79 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. Maryland MD			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 3223 Gwynns Falls Parkway				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Printer		12b. KIND OF BUSINESS OR INDUSTRY Printing Co.	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland 13c. COUNTY Baltimore 13d. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO					13e. STREET ADDRESS 3223 Gwynns Falls Pkwy.				
14. FATHER'S NAME FIRST MIDDLE LAST Charles H. Wells					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Henrietta Dennis				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW 11		17. INFORMANT ADDRESS 3223 Gwynns Falls Pkwy. Mrs. Jessie C. Wells					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 1629 IMMEDIATE CAUSE (a) METASTATIC BRONCHOGENIC CARCINOMA (TO BRAIN) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH: 10 MOS.									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: PULMONARY EMPHYSEMA									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) was not present attended the deceased from 10-6- 19 69 to 10-29 19 82 , that (I) was saw the deceased alive on 10-18- 19 82 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was not (did not) view the body after death.									
22b. SIGNATURE Carlton L. Sexton, M.D.					DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>			22c. DATE SIGNED 11-2-82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Carlton L. Sexton, M.D.					22e. ADDRESS Baltimore Life Building 901 N. Howard Street, Balto. 21201				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Nov. 4, 1982		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Maryland			
24. FUNERAL DIRECTOR NAME Herbert E. Wutter - 3035 W. North Ave.					25a. DATE REC'D. BY REGISTRAR NOV 8 1982		25b. REGISTRAR'S SIGNATURE John J. Connel		

Carlton J. Nelson, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 3 4 2 REG. NO.						
1. FOR STATE REGISTRAR																
1. DECEASED NAME (TYPE OR PRINT)					FIRST MIDDLE LAST					2a. DATE OF DEATH MONTH DAY YEAR					2b. HOUR	
Antoinette M West										Oct. 11, 1982					3:21 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR			6. AGE (IN YEARS LAST BIRTHDAY)			IF UNDER 1 YEAR MONTHS DAYS			IF UNDER 24 HRS. HOURS MIN.			
Female		Cauc.		2 5 36			46 YRS.									
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH									
Md		USA					Baltimore City MD									
10. CITY OR TOWN OF DEATH					11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)					12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)					12b. KIND OF BUSINESS OR INDUSTRY	
Balto.					Wyman Park Health System					Housewife						
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS					
MD					Balto		Balto.		YES		3304 Keswick Rd. Balto, MD 21211					
14. FATHER'S NAME FIRST MIDDLE LAST					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST											
Burkhardt					Rebber					Margaret Raider						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS									
Unknown					213-34-6486		Harry West 3304 Keswick Rd. Balto, MD 21211									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 2396 Cardio pulmonary arrest										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Brain stem infarct										20 min.						
DUE TO, OR AS A CONSEQUENCE OF (c) (K) frontal lobe brain tumor										5 days						
DUE TO, OR AS A CONSEQUENCE OF (c) (K) frontal lobe brain tumor										3 mos.						
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:																
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE								
22a. I certify that (I) (this hospital) attended the deceased from 10/6/82, 1982, to 10/11, 1982, that (I) (we) lost saw the deceased alive on 10/11, 1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																
22b. SIGNATURE DEGREE								22c. DATE SIGNED								
Carol S. Ramsey D.O.								10/11/82								
22d. PHYSICIAN'S NAME (TYPE OR PRINT)								22e. ADDRESS								
Carol S. Ramsey D.O.								Wyman Park Health System								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION CITY OR TOWN COUNTY STATE						
Burial				10/14/82		Most Holy Redeemer				Baltimore Maryland						
24. FUNERAL DIRECTOR NAME ADDRESS								25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE				
A. Alan Seitz Funeral Home 3818 Roland Ave.								OCT 14 1982				John J. Canine				

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, IT MUST BE EXECUTED BY A JUDGE OF THE COURT OF COMMON PLEAS, OR BY A JUDGE OF THE DISTRICT COURT OF BALTIMORE. IF THE DEATH IS SUSPECTED TO BE A SUICIDE, THE CERTIFICATE SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR THE FUNERAL DIRECTOR. PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH THE VITAL RECORDS DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. FOR STATE REGISTRAR										2. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR									
1. DECEASED NAME (TYPE OR PRINT) VERONICA S. WESTCOTT										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR <input type="checkbox"/> HOUR									
3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 2 2 1895		6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS.		7. IF UNDER 1 YR. MONTHS DAYS		7. IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD 10-24-82		2d. HOUR 5PM					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland				7b. CITIZEN OF WHAT COUNTRY? U. S. A.				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 2109 McCulloh Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife				12b. KIND OF BUSINESS OR INDUSTRY Home							
13a. STATE Maryland				13b. COUNTY				13c. CITY OR TOWN Baltimore				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
14. FATHER'S NAME FIRST MIDDLE LAST William Upshur				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Odie Deaver				16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. 212-07-0053							
17. INFORMANT UpperMalboro, Maryland 20772				Mrs. Veronica Norwood 316 Ridgely St.															
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH					
PART I DEATH WAS CAUSED BY:																			
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease																			
4292																			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.																			
DUE TO, OR AS A CONSEQUENCE OF (b)																			
DUE TO, OR AS A CONSEQUENCE OF (c)																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (b).																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .																			
ACTUAL SIGNATURE Margarita A. Korell, M.D.				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER				DATE SIGNED 10-25-82							
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street															
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE				23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel County, Md.							
24. FUNERAL DIRECTOR NAME Herbert E. Nutter				ADDRESS Baltimore Maryland 21216				25a. DATE REC'D. BY REGISTRAR OCT 26 1982				REGISTRAR'S SIGNATURE John J. Canale							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

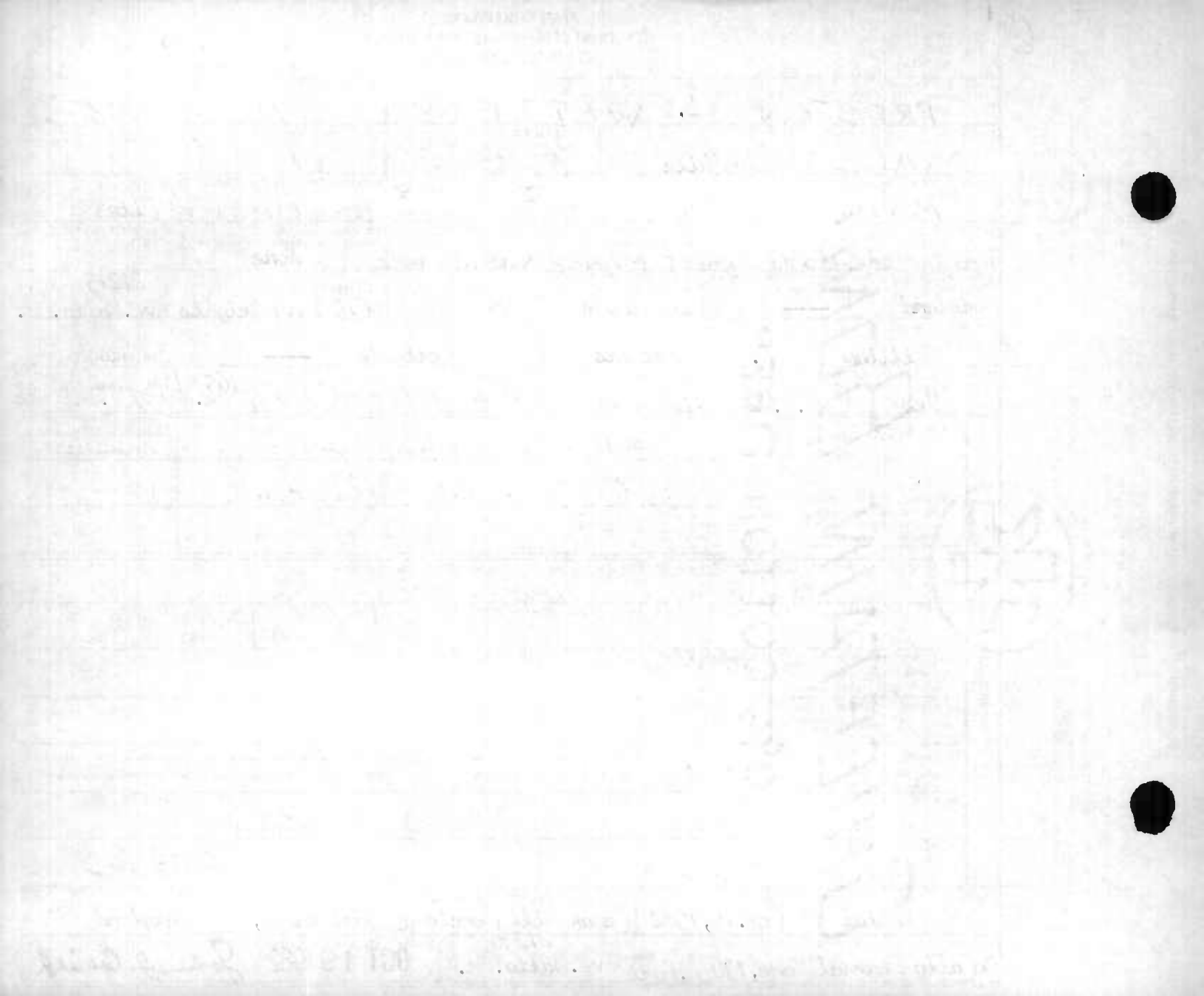
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 4 4

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) PRESTON L. WETTERS			2a. DATE OF DEATH MONTH DAY YEAR 10-17-82			2b. HOUR 5:15 ^{PM}			
3. SEX MALE		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5-30-21		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 5 15 00 00	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. USA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.			
10. CITY OR TOWN OF DEATH BALTIMORE-Md		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PLEASANT-MANOR-NURSING-HOME				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY ---		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4615 Park Heights Ave. Balto. Md.	
14. FATHER'S NAME FIRST MIDDLE LAST William E. Wetters				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Gertrude --- Sudbrook					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 215-12-8265		17. INFORMANT G.M. Haywood L.P.N.		ADDRESS 1653 Langford Rd. Balt. Md.		17b. V. Wetters	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer - Respiratory arrest 4100 DUE TO, OR AS A CONSEQUENCE OF (b) Acute myocardial infarction DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary embolism								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 minutes 15 min	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION 10-17-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED lung cancer				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5214 Harford Rd. Balt. Md.					
22a. I certify that (I) (this hospital) attended the deceased from 10-17-82 to 10-17-82 , that (I) (we) last saw the deceased alive on 10-17-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE James Punzalan				DEGREE 1				22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) James Punzalan				22e. ADDRESS 5214 Harford Rd. Balt. Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 19, 1982		23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME ADDRESS McCutty Funeral Home, 130 E. Font Ave. Balto. Md.				25a. DATE REC'D. BY REGISTRAR OCT 19 1982		25b. REGISTRAR'S SIGNATURE John J. Carver			



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 4 5
REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) RALPH DAVID WETZEL			2a. DATE OF DEATH MONTH DAY YEAR OCT. 21, 1982		2b. HOUR A 12:25 _M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Sept. 18, 1948	6. AGE (IN YEARS LAST BIRTHDAY) 36 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security		12b. KIND OF BUSINESS OR INDUSTRY NSA

13a. STATE Maryland			13b. COUNTY Anne Arundel	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 7602 Beaver Rd.	21061
14. FATHER'S NAME FIRST MIDDLE LAST Ralph W. Wetzel			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mae A. Spence				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) Viet Nam 216-48-9994		17. INFORMANT ADDRESS Mrs. Ellen M. Wetzel Same as #13			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 2015 IMMEDIATE CAUSE (a) <u>Cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Respiratory</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Hodgkin's Disease - Stage IV - Nodular Sclerosing</u>		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs 7 years
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>Interstitial lung disease</u>			
19a. DATE OF OPERATION Open lung biopsy	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Interstitial lung disease	20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/31</u> , 19 <u>82</u> , to <u>10/21</u> , 19 <u>82</u> , that (I) (we) lost <u>saw the deceased alive on</u> <u>10/21</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE <u>Daniel E. Ford, M.D.</u>	DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>	22c. DATE SIGNED 10/21/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DANIEL E. FORD, M.D.	22e. ADDRESS Johns Hopkins Hospital, Baltimore Md 21205		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation	23b. DATE 10/25/1982	23c. NAME OF CEMETERY OR CREMATORY Security Process, Inc.	23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto., Md.
24. FUNERAL DIRECTOR NAME McCully Funeral Home of Pasadena		25a. DATE REC'D. BY REGISTRAR OCT 26 1982	25b. REGISTRAR'S SIGNATURE John J. Smith

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Possession of this certificate is retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon paper of page 2 and 3 and forward them to the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 4 6
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) EVA LILLIAN WHEELER			2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 23, 1982		2b. HOUR 7:50 AM
3. SEX Female	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR Nov. 16, 1888	6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD		
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5910 Falkirk Rd.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Baltimore	13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13d. STREET ADDRESS 5910 Falkirk Rd. 21239
14. FATHER'S NAME FIRST MIDDLE LAST Wilmot Lincoln Carrington			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Mowry		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 086-30-1410	17. INFORMANT ADDRESS Mrs. Annie W. O'Hara Same		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic Heart Disease</u> <u>4140</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>11 years</u>					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (the hospital) attended the deceased from <u>Nov 28</u> , 19 <u>71</u> , to <u>Oct 23</u> , 19 <u>82</u> , that (I) last saw the deceased alive on <u>Oct 23</u> , 19 <u>82</u> , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) was not did not view the body after death.					
22b. SIGNATURE <u>Charles E. Shaw, M.D.</u>		DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <u>Oct 23 82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles E. Shaw, M.D.		22e. ADDRESS 607 W. Joppa Rd. Towson, Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial-Transit	23b. DATE Oct. 26, 1982	23c. NAME OF CEMETERY OR CREMATORY Fort Hill		23d. LOCATION CITY OR TOWN COUNTY STATE Auburn, Cayuga Co. New York	
24. FUNERAL DIRECTOR NAME Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212		ADDRESS 6500 York Rd.		25a. DATE REC'D. BY REGISTRAR OCT 28 1982	25b. REGISTRAR'S SIGNATURE <u>John J. Connel</u>

12-11

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12-11-1940

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 3 4 7	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT)		FIRST MAE		MIDDLE C. C.		LAST WHEELER		20. DATE OF DEATH MONTH DAY YEAR 10/29/1982		2b. HOUR P. 5 M.	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 2 4 16		6. AGE (IN YEARS LAST BIRTHDAY) 66 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) North Charles General Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY Own Home			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md		13b. CITY OR TOWN Baltimore		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 7312 Fairbrook Road		21207			
14. FATHER'S NAME FIRST MIDDLE LAST James Albert Jackson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ruth Viola Widerman		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 214-03-3238		17. INFORMANT 4865 Melbourne Road Gary Allan Thrasher Balto. Md. 21229			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1629 CARCINOMA Lung With DUE TO, OR AS A CONSEQUENCE OF (b) Brain metastasis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 months											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a):											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 10/5/1982, to 10/29/1982, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Arzaria		DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/29/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS North Charles Gen Hospital BALTIMORE MD 21218									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/30/82		23c. NAME OF CEMETERY OR CREMATORY Westview Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Catonsville Balto Md					
24. FUNERAL DIRECTOR NAME Witzke, P.A.		ADDRESS 1630 Edmondson Ave Catonsville, Md. 21228				DATE REC'D BY REGISTRAR 11 NOV 1 1982					

THE NEW YORK PUBLIC LIBRARY
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 6 3 4 8 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES J. WHITAKER				2a. DATE OF DEATH MONTH DAY YEAR 10-20-82		2b. HOUR MIN. 1:05pm	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 01 15 29		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) NORTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTO., CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CORRECTIONAL OFFICER		12b. KIND OF BUSINESS OR INDUSTRY MARYLAND	
13a. STATE MARYLAND		13b. COUNTY ---		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST JAMES WHITAKER				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST RAYWILL TODD			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II 156-20-2326		17. INFORMANT ADDRESS MARY P. WHITAKER 405 PARKSLEY AVE. 21223			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 Myocardial Infarction IMMEDIATE CAUSE (a) } DUE TO, OR AS A CONSEQUENCE OF (b) } Atherosclerotic Vascular Disease Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) } APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 24 hours							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a):							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10-19, 19 82 to 10-20, 19 82 , that (I) (we) last saw the deceased alive on 10-20, 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Lawrence Zeidman MD				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/20/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) LAWRENCE ZEIDMAN, M.D.				22e. ADDRESS ST. AGNES HOSPITAL, 900 S. CATON AVENUE			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-23-82		23c. NAME OF CEMETERY OR CREMATORY LOUDON PARK		23d. LOCATION CITY OR TOWN COUNTY STATE BALTIMORE CITY MARYLAND	
24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229				25a. DATE REC'D. BY REGISTRAR OCT 22 1982		25b. REGISTRAR'S SIGNATURE John J. Conish	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the Division of Health with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a medical examination required.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 6 3 4 9 REG. NO.			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST BABY BOY WHITE			
3 SEX Male				4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 10 7 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? Maryland		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnas Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) None		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NOT IN HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13a. COUNTY Wic.				13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Unknown				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Usa R. White			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Usa R. White Same as # 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 7705 IMMEDIATE CAUSE (a) INTRAVENTRICULAR HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (b) PULMONARY ANECTASIS DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) _____							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Michael E. Palgar</i>				DEGREE		22c. DATE SIGNED 10/9/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Michael E. Palgar				22e. ADDRESS St. Agnas Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/26/82		23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.	
24. FUNERAL DIRECTOR Witzke				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE NOV 1 - 1982 John J. Conner			



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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 5 0

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) CHARLES L. WHITE			2a. DATE OF DEATH MONTH DAY YEAR 10 12 82			2b. HOUR 9:40A M	
3. SEX MALE		4. RACE NEGROID		5. DATE OF BIRTH MONTH DAY YEAR NOV. 15, 1928		6. AGE (IN YEARS LAST BIRTHDAY) 53 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CTY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC LOCH RAVEN BLVD. BALTO. MD				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Maintenance	
						12b. KIND OF BUSINESS OR INDUSTRY Business	

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD.		13b. COUNTY BALTO		13c. CITY OR TOWN BALTO		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2022 Ellsworth St.	
14. FATHER'S NAME FIRST MIDDLE LAST EMORY White Sr.				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST BEATRICE Miles					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 9-23-32/9-20-33		17. INFORMANT ADDRESS Sodonia Taylor 2022 Ellsworth St.			

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4149 DUE TO, OR AS A CONSEQUENCE OF (b) SEVERE CORONARY Artery Disease DUE TO, OR AS A CONSEQUENCE OF (c) 2 10 yrs		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: a Diabetes Mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			

22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 7, 1982, to October 12, 1982, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.		22b. SIGNATURE Sharon K. Dollymore MD DEGREE MD		22c. DATE SIGNED 10/14/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sharon K. Dollymore MD		22e. ADDRESS 3900 Loch Raven Blvd. Balto. Md 21218			

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-16-82		23c. NAME OF CEMETERY OR CREMATORY Christ M.E. Church Darville Md.		23d. LOCATION CITY OR TOWN COUNTY STATE	
24. FUNERAL DIRECTOR NAME Calvin B. Scruggs				24. ADDRESS 1412 E. Preston St.		25a. DATE REC'D. BY REGISTRAR OCT 15 1982	
				25b. REGISTRAR'S SIGNATURE John J. Smith			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 and 5 are to be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by page 3.

item 6 #G574 12/3/82 ph

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 5 1

FOR
1 - STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Estelle WHITE			2a. DATE OF DEATH MONTH DAY YEAR October 23, 1982		2b. HOUR 12:08A
3. SEX Female	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 3 21 22		6. AGE (IN YEARS LAST BIRTHDAY) 60 - 61 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE Maryland			13b. COUNTY Baltimore	13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST - - -			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST - - -		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) N/A		17. INFORMANT ADDRESS Patricia White 1012 Mosher St. 1st Fl.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4100 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Recent Right Cerebrovascular Accident DUE TO, OR AS A CONSEQUENCE OF (c) Cerebrovascular Accident Occurred Between October 22-23, 1982.					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (X) (this hospital) attended the deceased from October 13, 1982 , to October 23, 1982 , that (X) (we) last saw the deceased alive on October 23, 1982 , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death.					
22b. SIGNATURE [Signature]		DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/23/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Sepehr Soltani, M.D.		22e. ADDRESS c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/30/82	23c. NAME OF CEMETERY OR CREMATORY Mount Zion Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md.
24. FUNERAL DIRECTOR NAME ADDRESS Wm. C. March F/H 1101 E. North aVenue		25a. DATE REC'D. BY REGISTRAR OCT 27 1982		25b. REGISTRAR'S SIGNATURE [Signature]	

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October 23

October 13

St. Vincent General Hospital

Cerebrovascular Accident occurred between October 23-25, 1972.

Dr. J. H. Cerebrovascular Accident

Neurological Infection

St. Vincent General Hospital

October 13

October 23

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26352	
1. DECEASED NAME (TYPE OR PRINT) Joyce A. White							2a. DATE KNOWN OF DEATH 9 30 1982		2b. HOUR M		
3. SEX Female		4. RACE White		5. DATE OF BIRTH July 2 1979		6. AGE (IN YEARS) 3 YRS.		7c. DATE PRONOUNCED DEAD 9 30 1982		7d. HOUR 2:20A M	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			7b. CITIZEN OF WHAT COUNTRY? U.S.A.			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Union Memorial Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Dependent		12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4532 Harford Rd. 21214	
14. FATHER'S NAME Timothy White						15. MOTHER'S MAIDEN NAME Dolores Garcia					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. None		17. INFORMANT Mr. Timothy White				ADDRESS Same as # 13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Meningitis</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an autopsy <input type="checkbox"/> , inspection <input checked="" type="checkbox"/> , inquiry <input type="checkbox"/> , and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <i>Thomas D. Smith</i>				TITLE (SPECIFY) M.D. Deputy Chief				DATE SIGNED 9/30/82			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St				Balto., Md.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/2/82		23c. NAME OF CEMETERY OR CREMATORY Most Holy Redeemer			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc.						ADDRESS Baltimore, Md.		25a. DATE REC'D. BY REGISTRAR OCT 1 1982		25b. REGISTRAR'S SIGNATURE <i>John J. Connelley</i>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use on the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND									
DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 2 2 6 3 5 3				
1. FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Julia J White					2a. DATE OF DEATH MONTH DAY YEAR 10 - 8 - 82			2b. HOUR 6:30 M	
3. SEX female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 25 18		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balt. move MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY		13c. CITY OR TOWN Balt		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2920 Boarman Ave	
14. FATHER'S NAME FIRST MIDDLE LAST Vernon Francis				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Veronica Branton					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Joseph White 2920 Boarman Ave			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiogenic shock DUE TO, OR AS A CONSEQUENCE OF (b) Acute Myocardial Infarction DUE TO, OR AS A CONSEQUENCE OF (c) Ventricular Arrhythmia									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from 10-8 19 82 to 10-8 19 82 , that (I) (we) last saw the deceased alive on 10-8 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Eugene Giles M.D. DEGREE						22c. DATE SIGNED 10-8-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Eugene Giles M.D.						22e. ADDRESS 2600 Liberty Heights Ave.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 10/12/82		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem		23d. LOCATION CITY OR TOWN COUNTY STATE Balt., Md.		
24. FUNERAL DIRECTOR NAME Leroy A Sytt ADDRESS 4600 Liberty Heights Ave						25a. DATE REC'D. BY REGISTRAR 10/13/82		25b. REGISTRAR'S SIGNATURE John J. Canine	



[Faint, illegible handwritten text, likely bleed-through from the reverse side of the page.]

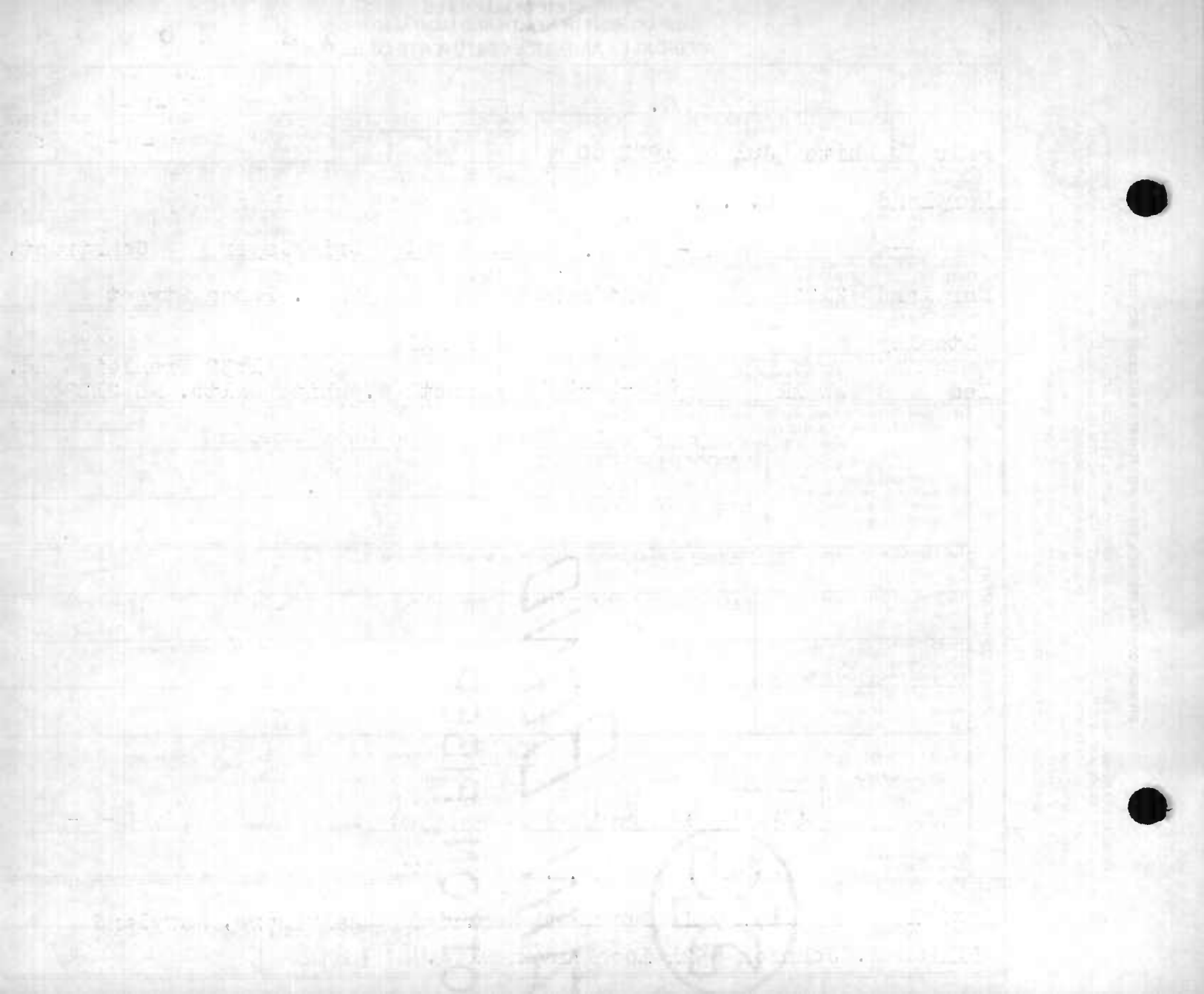
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1- FOR STATE REGISTRAR		2 2 6 3 5 4	
1. DECEASED NAME (TYPE OR PRINT)		2a. DATE KNOWN OF DEATH	
KENNETH G. WHITE		10-16-82	
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (IN YEARS)
Male	White	Jul 05 1922	60 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)	7b. CITIZEN OF WHAT COUNTRY?	8. MARRIED	9. BALTIMORE CITY OR COUNTY OF DEATH
Maryland	U.S.A.	NEVER MARRIED	Baltimore City
10. CITY OR TOWN OF DEATH	11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION	12a. USUAL OCCUPATION	12b. KIND OF BUSINESS OR INDUSTRY
Baltimore	Woods - 3500 S. Hanover Street	Bricklayer	Construct.
13a. STATE	13b. COUNTY	13c. CITY OR TOWN	13d. INSIDE CITY LIMITS?
Maryland	21224	Baltimore	YES
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME	16. SOCIAL SECURITY NO.	
Stanley	Nellie Door	214-18-2070	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?	16b. SOCIAL SECURITY NO.	17. INFORMANT	
Yes	WW 11	Kenneth G. White	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease and			
4292			
Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last:			
(b) fatty liver			
DUE TO, OR AS A CONSEQUENCE OF			
(c)			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).			
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?	
20. AUTOPSY?			
YES		NO	
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH		21b. TIME OF INJURY	
		HOUR A.M. MONTH DAY YEAR	
		P.M. 19	
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)	
NOT WHILE AT WORK			
21f. LOCATION			
CITY OR TOWN		COUNTY STATE	
22a. I certify that I took charge of the remains described above, held on		Autopsy	
death resulted from: Natural causes		Inspection	
Accident		Inquiry	
Suicide		and in my opinion	
Homicide			
Undetermined manner			
ACTUAL SIGNATURE		TITLE (SPECIFY)	
Margarita A. Koroll, M.D.		Assistant	
EXAMINER'S NAME (TYPE OR PRINT)		MEDICAL EXAMINER	
ADDRESS		DATE SIGNED	
111 Penn Street		10-16-82	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)	23b. DATE	23c. NAME OF CEMETERY OR CREMATORY	23d. LOCATION
Burial	10/19/82	Moreland Memorial	Baltimore, Maryland
24. FUNERAL DIRECTOR	25a. DATE RECD. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE
William E. Johnson	OCT 18 1982		John J. Carver



Items #18a-22a Film G574 12/8/82 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
FOR Item 13e Phone 10-20-20

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO. 2 6 3 5 5

1. DECEASED NAME (TYPE OR PRINT) Nathaniel				2a. DATE KNOWN OF DEATH ESTI- MATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 1 19 82				2b. HOUR M	
3. SEX m	4. RACE C	5. DATE OF BIRTH MONTH DAY YEAR 2 21 56	6. AGE (IN YEARS LAST BIRTHDAY) 26 YRS.	IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN		2c. DATE PRONOUNCED DEAD 10 1 19 82	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Baltimore md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Provident Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) —		12b. KIND OF BUSINESS OR INDUSTRY —	
13a. STATE md		13b. COUNTY Balto		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1803 Moreland Ave			
14. FATHER'S NAME FIRST MIDDLE LAST Nathaniel White				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Reyes Johnson					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT NAME ADDRESS My Lawrence White Knechtel Ave 6705					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 3049 IMMEDIATE CAUSE (a) Narcotism DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?						20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .									
ACTUAL SIGNATURE Thomas D. Smith		TITLE (SPECIFY) Deputy Chief				MEDICAL EXAMINER		DATE SIGNED 10/2/82	
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.		ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) B		23b. DATE 10/16/82		23c. NAME OF CEMETERY OR CREMATORY Graves of St. Anne				23d. LOCATION CITY OR TOWN COUNTY STATE md.	
24. FUNERAL DIRECTOR NAME ADDRESS Joseph L. Rura 2222 W York Ave				25a. DATE REC'D. BY REGISTRAR OCT 4 - 1982		25b. REGISTRAR'S SIGNATURE John J. Smith			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, DEATH SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, DEATH SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, DEATH SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH.

TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH. WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE

TO : SAC, NEW YORK
FROM : SAC, NEW YORK
SUBJECT: [Illegible]

DATE: [Illegible]

RE: [Illegible]

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2. [Illegible]

3. [Illegible]

4. [Illegible]

5. [Illegible]

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15. [Illegible]

16. [Illegible]

17. [Illegible]

18. [Illegible]

19. [Illegible]

20. [Illegible]

RECEIVED
FEDERAL BUREAU OF INVESTIGATION
U. S. DEPARTMENT OF JUSTICE



WHITEHEAD, DEBORAH

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that death of a patient be excused within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a report filed.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE									
FOR Item 19b&b Film 574 cn 1- STATE 12-7-82 REGISTRAR CERTIFICATE OF DEATH									
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Deborah Whitehead						2a. DATE OF DEATH MONTH DAY YEAR 10/09/82		2b. HOUR 3:50PM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR March 20, 1958		6. AGE (IN YEARS LAST BIRTHDAY) 24 YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kentucky		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) John Hopkins Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Michigan				13b. CITY OR TOWN Wentland		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET ADDRESS 2009 Eastport 48185	
14. FATHER'S NAME FIRST MIDDLE LAST James Robertson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maxine ? ?					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No				16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS David Whithead Same			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY ARREST 2050 DUE TO, OR AS A CONSEQUENCE OF (b) INTERSTITIAL PNEUMONIA Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) GRAFT VERSUS HOST DISEASE									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 MINUTE 4 DAYS 20 DAYS
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1.									
19a. DATE OF OPERATION 8-20-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Acute Myelomonocytic Leukemia				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) this hospital attended the deceased from 10/1/82 , 19 82 , to 10/19/82 , 19 82 , that (I) (we) lost saw the deceased alive on 10/19/82 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE Neil M. Bressler MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10/19/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NEIL M. BRESSLER				22e. ADDRESS JOHNS HOPKINS HOSPITAL					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/12/82		23c. NAME OF CEMETERY OR CREMATORY Buck Hill Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Barran County Kentucky			
24. FUNERAL DIRECTOR NAME Leonard J. Ruck, Inc. Baltimore, Maryland				25a. DATE REC'D. BY REGISTRAR OCT 18 1982		25b. REGISTRAR'S SIGNATURE John J. Smith			

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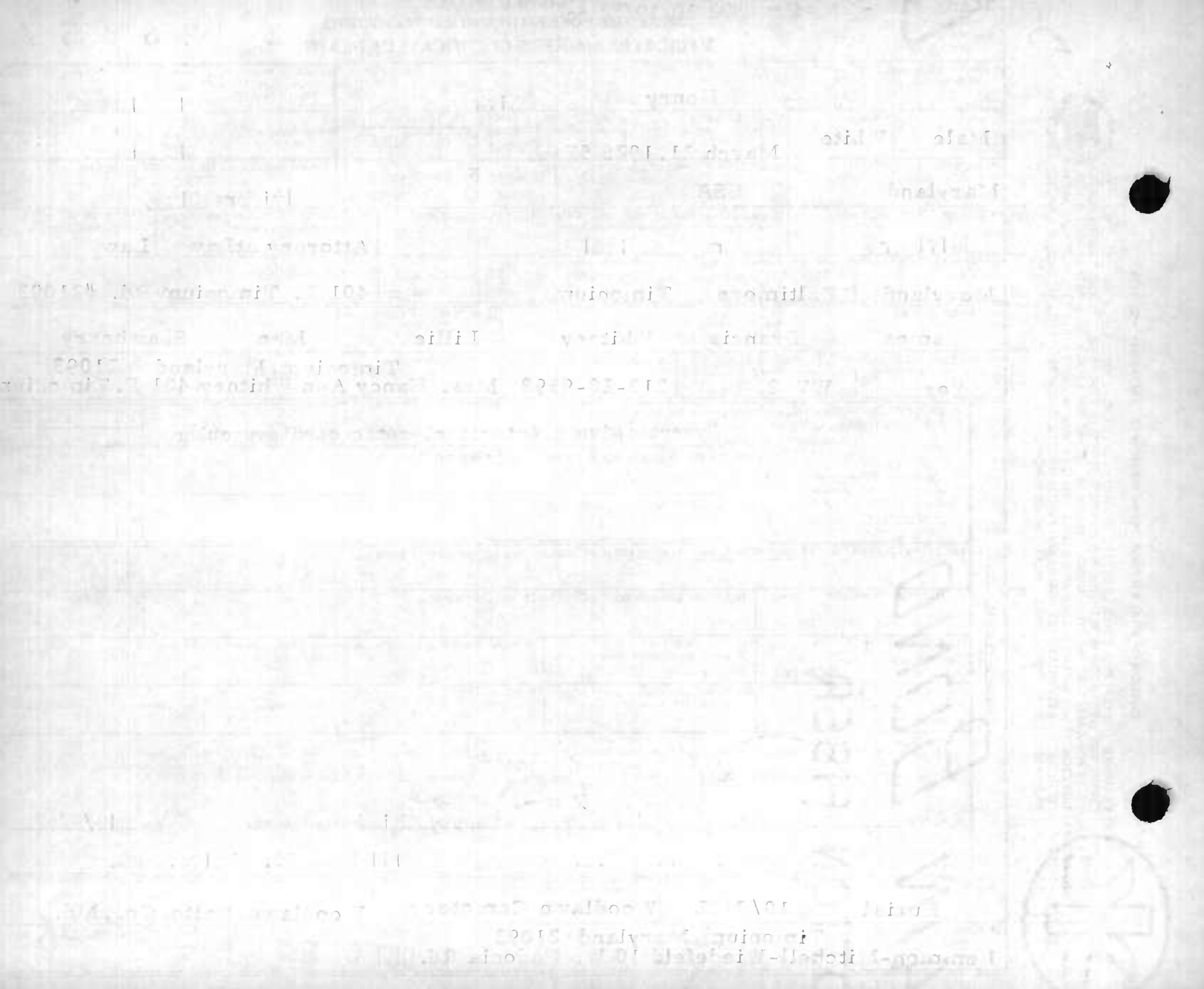
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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR RECORDS. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL, TRANSIT PERMIT, PAGES 1 AND 2 SHOULD BE FILED WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

1. DECEASED NAME (TYPE OR PRINT)										20. DATE KNOWN OF DEATH		26. HOUR	
James Henry Whitney										DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR		26. HOUR	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS)		7. IF UNDER 24 HRS.		21. DATE PRONOUNCED DEAD		24. HOUR	
Male		White		March 21, 1925		57 YRS.		IF UNDER 24 HRS.		10 1 19 82		6:25 P.M.	
10. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH	
Maryland				USA								Baltimore City, MD	
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore				Mercy Hospital				Attorney at Law				Law	
13a. STATE				13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS			
Maryland				Baltimore		Timonium		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		401 E. Timonium Rd. #21093			
14. FATHER'S NAME						15. MOTHER'S MAIDEN NAME							
James Francis Whitney						Lillie Mae Shawberry							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES?				16b. SOCIAL SECURITY NO.		17. INFORMANT				ADDRESS			
Yes				WW 2		213-20-9598				Mrs. Nancy Ann Whitney 401 E. Timonium			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY: Hypertensive & Arteriosclerotic cardiovascular													
IMMEDIATE CAUSE (a) 4029													
DUE TO, OR AS A CONSEQUENCE OF disease													
(b)													
DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).													
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								20. AUTOPSY?	
												YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
				HOUR A.M. MONTH DAY YEAR									
				P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION					
								STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .													
ACTUAL SIGNATURE				TITLE (SPECIFY)								DATE SIGNED	
Thomas D. Smith, M.D.				M. Deputy Chief								10/2/82	
EXAMINER'S NAME (TYPE OR PRINT)				ADDRESS									
Thomas D. Smith, M.D.				111 Penn St. Balto., MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION			
Burial				10/8/82		Woodlawn Cemetery				Woodlawn, Balto. Co., Md.			
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE					
Lemmon-Mitchell-Wiedefeld 10 W. Padonia Rd.				OCT 6 1982									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

1- FOR STATE REGISTRAR				STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 2 6 3 5 8 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) CHRISTOPHER DANIEL WHITT BABY BOY WHITT				2a. DATE OF DEATH MONTH DAY YEAR 10/28/82		2b. HOUR 3:10 AM			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 10 25 82		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS — 2 16 47		7. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD.	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		9. CITIZEN OF WHAT COUNTRY? UNITED STATES		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD.		12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13. CITY OR TOWN OF DEATH BALTIMORE CITY		14. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL		15. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY Baltimore 13c. CITY OR TOWN Baltimore		16. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		17. STREET ADDRESS 6841 WATERLOO RD 21227	
18. FATHER'S NAME FIRST MIDDLE LAST LARRY WHITT		19. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SANDRA Johns		20. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES)		21. SOCIAL SECURITY NO.		22. INFORMANT ADDRESS Sandra Whitt Same as #13	
23. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 7690 IMMEDIATE CAUSE (a) SEVERE HYALINE MEMBRANE DISEASE DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) Prematurity 28 weeks gestation DUE TO, OR AS A CONSEQUENCE OF (c) Grade 4 intraventricular hemorrhage				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 days 16 hours 2 days 16 hours 1 day		PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): Anemia secondary to intraventricular hemorrhage			
24. DATE OF OPERATION		25. CONDITION FOR WHICH OPERATION WAS PERFORMED		26. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		27. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
28. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		29. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		30. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)		31. LOCATION STREET CITY OR TOWN COUNTY STATE			
32. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		33. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		34. LOCATION STREET CITY OR TOWN COUNTY STATE		35. I certify that (I) (this hospital) attended the deceased from 10/25 , 19 82 , to 10/28 , 19 82 , that (I) (we) last saw the deceased alive on 10/28 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death (3:10 AM)			
36. SIGNATURE Mark Harris MD		37. PHYSICIAN'S NAME (TYPE OR PRINT) MARK HARRIS MD		38. ADDRESS 500 NOTTINGHAM RD, BALTIMORE, MD		39. DATE SIGNED 10/28/82			
40. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		41. DATE 11/1/82		42. NAME OF CEMETERY OR CREMATORY Ivy Hill		43. LOCATION CITY OR TOWN COUNTY STATE Laurel Md			
44. FUNERAL DIRECTOR NAME Witzke, P.A.		45. ADDRESS 1630 Edmondson Avenue Catonsville, Md. 21228		46. DATE REC'D. BY REGISTRAR NOV 1 1982		47. REGISTRAR'S SIGNATURE [Signature]			

UNITED STATES DEPARTMENT OF JUSTICE
FEDERAL BUREAU OF INVESTIGATION

CHIEF, TOLSON, CHASE

WASH. D.C.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 5 9
REG. NO.

1. DECEASED NAME (TYPE OR PRINT) DAVID LLOYD WHITTINGTON		2a. DATE OF DEATH MONTH DAY YEAR OCTOBER 12, 1982		2b. HOUR 11:22AM	
3. SEX MALE	4. RACE C	5. DATE OF BIRTH MONTH DAY YEAR 1 12. 88		6. AGE (IN YEARS LAST BIRTHDAY) YRS. 9 MONTHS 12 DAYS IF UNDER 1 YEAR HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) M.D.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) THE JOHNS HOPKINS HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. STATE M.D.		13b. COUNTY SOMERSET	13c. CITY OR TOWN MARION	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST DAVID J WHITTINGTON		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ROSALIND MARIE RHOCK			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS ROSALIND M. RHOCK, P.O. Box 44	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) hemodynamic instability - hypotension DUE TO, OR AS A CONSEQUENCE OF (b) probable sepsis DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Severe bronchopulmonary dysplasia					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)	
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 09/07 , 19 82 , to 10 , 19 82 , that (I) (we) last saw the deceased alive on 10/12 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE Renee A. Cousins		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/12/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Renee A. Cousins		22e. ADDRESS THE JOHNS HOPKINS HOSPITAL			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-16-82		23c. NAME OF CEMETERY OR CREMATORY Liberia	
23d. LOCATION CITY OR TOWN COUNTY STATE Marion Somerset MD		23e. DATE REC'D. BY REGISTRAR OCT 21 1982			
24. FUNERAL DIRECTOR NAME Addie Jones		ADDRESS 467 Somerset Ave. Prince		25a. REGISTRAR'S SIGNATURE John J. Canine	

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DATE 11/15/54

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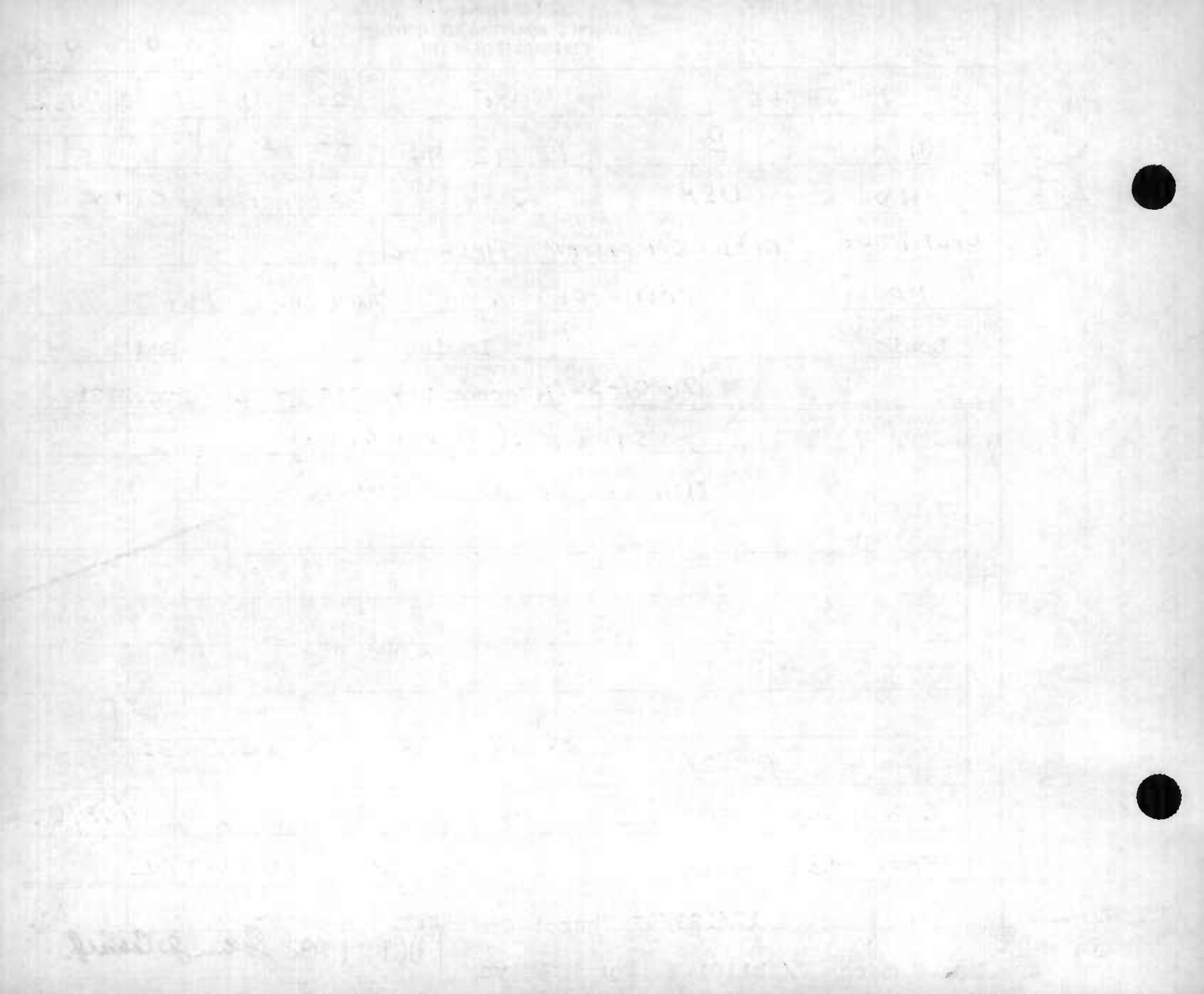
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and consulted.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										REG. NO. 8 2 2 6 3 6 0		
1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST	MIDDLE	LAST	2a. DATE OF DEATH		MONTH	DAY	YEAR	2b. HOUR
		JAMES				WHYE	10/10		10	20	82	8:15 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS		
M		B		12 12 94		88 yrs.		MONTHS		DAYS		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH						
MD.		USA				BALTIMORE CITY				MD.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY						
BALTIMORE		GOOD SAMARITAN HOSPITAL										
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)		13b. STATE		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS				
MD.				BALTIMORE		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		718 MCCABE AVE.				
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		16. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS				
Lewis		Whye		216-07-5574		Vernon Whye		718 Mc Cabe Ave.		21212		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS						
No		216-07-5574		Vernon Whye		718 Mc Cabe Ave.		21212				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)												
PART I. DEATH WAS CAUSED BY:												
5950 IMMEDIATE CAUSE (a) STROKE (THROMBOTIC)												
DUE TO, OR AS A CONSEQUENCE OF												
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last												
(b) Chronic Renal Failure												
DUE TO, OR AS A CONSEQUENCE OF												
(c)												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).												
19a. DATE OF OPERATION												
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED												
20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>												
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>												
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)												
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR												
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)												
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK												
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)												
21f. LOCATION STREET CITY OR TOWN COUNTY STATE												
22a. I certify that (I) (this hospital) attended the deceased from 08/14/1982 to 10/20/1982, that (I) (we) last saw the deceased alive on 10/20/1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE DEGREE												
Brajaendra Singh MD												
22c. DATE SIGNED 10/20/82												
22d. PHYSICIAN'S NAME (TYPE OR PRINT)												
McDOUGALS												
22e. ADDRESS												
GOOD SAM. HOSPITAL												
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)												
BURIAL												
23b. DATE 10/23/82												
23c. NAME OF CEMETERY OR CREMATORY												
Church Cemetery												
23d. LOCATION CITY OR TOWN COUNTY STATE												
Monkton Md.												
24. FUNERAL DIRECTOR NAME ADDRESS												
Wm. C march F/ h1101 E. North AeAve												
25a. DATE REC'D. BY REGISTRAR												
OCT 21 1982												
25b. REGISTRAR'S SIGNATURE												
John J. Lander												



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by item 1.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH											
1. FOR STATE REGISTRAR		REG. NO. 8 2 2 6 3 6 1									
1. DECEASED NAME (TYPE OR PRINT)		FIRST		MIDDLE		LAST		2a. DATE OF DEATH MONTH DAY YEAR		2b. HOUR	
Marsha		Whye						10 08 82		9 34 M	
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS	
Female		Black		8 MONTH DAY YEAR 25 55		27 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH					
Md.		USA				Balto. City MD.					
10 CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		Lutheran Hospital									
13a. STATE		13b. CITY OR TOWN		13c. INSIDE CITY LIMITS?		13d. STREET ADDRESS					
Md.		Balto.		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		2708 W. Mosher St.					
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME									
FIRST MIDDLE LAST		FIRST MIDDLE LAST									
Walter		Whye		Margaret Lambert							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.		17 INFORMANT ADDRESS							
No		N/A		Margaret Whye 2708 W. Mosher St.							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY:										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
IMMEDIATE CAUSE (a) 4229											
DUE TO, OR AS A CONSEQUENCE OF (b) ALCOHOLIC AND/OR VIRAL MYOCARDITIS											
DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
		P.M. 19									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from 10.8.1982 to 10.8.1982, that (I) (we) last saw the deceased alive on 10.8.1982, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED			
10.8.82								10.8.82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
BURIAL		10/13/82		Mount Zion Cem.		Baltimore		Md.			
24. FUNERAL DIRECTOR NAME		455 ADDRESS				25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Wm. C. March F/H 1101 E. North Avenue						OCT 13 1982		John J. Connel			

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 6 2

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) NATHANIEL ERVIN WICKS			2a. DATE OF DEATH MONTH DAY YEAR 10 31 82			2b. HOUR 4:15PM			
3. SEX M		4. RACE Negro		5. DATE OF BIRTH MONTH DAY YEAR 8 21 27		6. AGE (IN YEARS LAST BIRTHDAY) 55 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE COUNTRY N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTO. CITY MD.			
10. CITY OR TOWN OF DEATH BALTO.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC, Baltimore, Maryland 21218				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Labor		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE md		13b. COUNTY BALTO.		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 961 Rosedale St	
14. FATHER'S NAME FIRST MIDDLE LAST Nathan Wicks				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Livingston					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW-II		17. INFORMANT MRS. Cousins		ADDRESS 961 N. Rosedale St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardio pulmonary arrest 1509 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) esophageal cancer DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min's 6 m's.									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: _____									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from October 20, 19 82 to October 31, 82 , that (I) (we) lost saw the deceased alive on October 31, 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE San Claus Houghton MD					DEGREE MD		22c. DATE SIGNED 11/1/82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) San Claus Houghton					22e. ADDRESS VAMC, Baltimore, Maryland 21218				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial			23b. DATE 11/3/82		23c. NAME OF CEMETERY OR CREMATORY McAdamsville Cen.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. md		
24. FUNERAL DIRECTOR NAME Betts Funeral Home					ADDRESS 1129 N. Caroline St.		25a. DATE REC'D. BY REGISTRAR NOV 5 1982		25b. REGISTRAR'S SIGNATURE John J. Connel

MEDICAL CERTIFICATION

99

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

NO

PO BOX 1011

CHIEF



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 6 3

REG. NO.

FOR
1. STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Ruby Wiggins</i>			2a. DATE OF DEATH MONTH DAY YEAR 10 13, 1982		2b. HOUR M
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 8 5 1907		6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) North Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Sinai Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland			13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Walter Carter			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emma Downing		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No	16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-28-3206		17. INFORMANT ADDRESS Julia Bates 937 N. Castle Street		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Constrictive Heart Failure</i> 4149 DUE TO, OR AS A CONSEQUENCE OF (b) <i>Coronary Vascular Disease</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c)					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <i>Seizure & Secondary to Cerebral Vascular Disease, UTI</i>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <i>1 JAN</i> , 19 <i>82</i> , to <i>OCT 13</i> , 19 <i>82</i> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <i>OCT 11</i> , 19 <i>82</i> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.					
22b. SIGNATURE <i>Howard H Bond</i>		DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/15/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT)		22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/18/82	23c. NAME OF CEMETERY OR CREMATORY Baltimore Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland
24. FUNERAL DIRECTOR Wm. C. March F/H, Inc. 1101 E. North Avenue			25a. DATE REC'D. BY REGISTRAR OCT 18 1982		
			25b. REGISTRAR'S SIGNATURE <i>John J. Carver</i>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 6 3 6 4 REG. NO.			
1. FOR STATE REGISTRAR				1. DECEASED NAME (TYPE OR PRINT)			
2. DATE OF DEATH MONTH DAY YEAR				2b. HOUR			
3. SEX				4. RACE			
5. DATE OF BIRTH MONTH DAY YEAR				6. AGE (IN YEARS LAST BIRTHDAY)			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)				7b. CITIZEN OF WHAT COUNTRY?			
8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH			
10. CITY OR TOWN OF DEATH				11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE				13b. CITY OR TOWN			
13c. INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO				13d. STREET ADDRESS			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO			
17. INFORMANT ADDRESS				18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR			
21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			
21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 9-23, 19 82, to 10-12, 19 82, that (we) last saw the deceased alive on 10-12, 19 82, and that in (my) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death.				22b. SIGNATURE DEGREE			
22c. DATE SIGNED				22d. PHYSICIAN'S NAME (TYPE OR PRINT)			
22e. ADDRESS				23a. BURIAL, CREMATION, REMOVAL (SPECIFY)			
23b. DATE				23c. NAME OF CEMETERY OR CREMATORY			
23d. LOCATION CITY OR TOWN COUNTY STATE				24. FUNERAL DIRECTOR NAME			
25a. DATE REC'D. BY REGISTRAR				25b. REGISTRAR'S SIGNATURE			

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

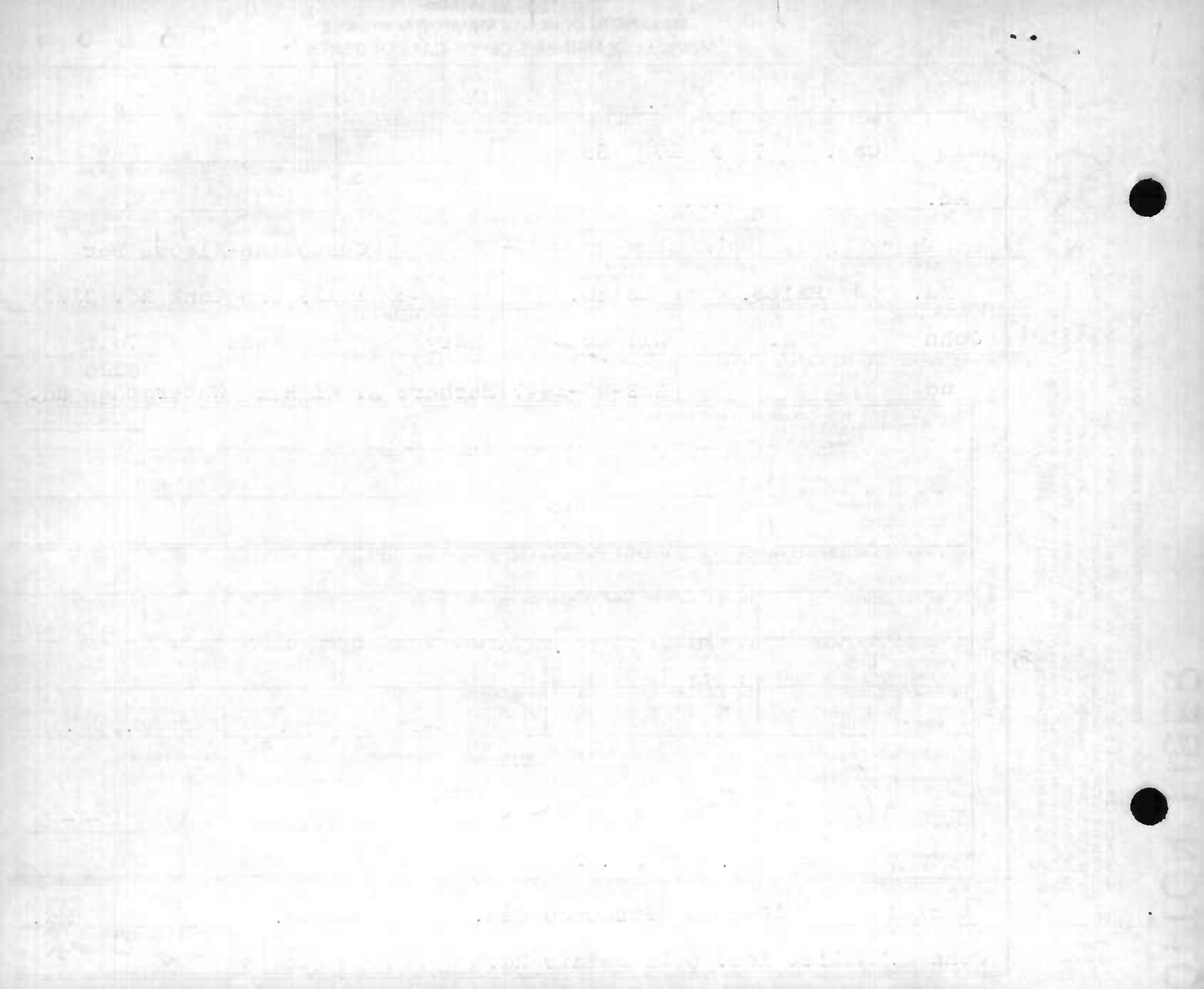
REG. NO.

FOR
1- STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <div style="text-align: center;">George W. Wilker</div>			2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR <div style="text-align: center;">10 7 1982</div>		2b. HOUR M <div style="text-align: center;">6:50 a. M.</div>
3 SEX <div style="text-align: center;">Male</div>	4. RACE <div style="text-align: center;">Cau.</div>	5. DATE OF BIRTH MONTH DAY YEAR <div style="text-align: center;">7 9 17 65 YRS.</div>	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS DAYS HOURS MIN	IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <div style="text-align: center;">Md.</div>		7b. CITIZEN OF WHAT COUNTRY? <div style="text-align: center;">U.S.A.</div>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. CITY OR TOWN OF DEATH <div style="text-align: center;">Baltimore</div>		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <div style="text-align: center;">University Hospital - STU</div>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <div style="text-align: center;">Custodian-Alcove Bar</div>	
13a. STATE <div style="text-align: center;">Md.</div>		13b. COUNTY <div style="text-align: center;">Balto.</div>		13c. CITY OR TOWN <div style="text-align: center;">Balto.</div>	
14. FATHER'S NAME FIRST MIDDLE LAST <div style="text-align: center;">John H. Wilker</div>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <div style="text-align: center;">Mary Anna Voit</div>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) <div style="text-align: center;">no</div>		16b. SOCIAL SECURITY NO. <div style="text-align: center;">219-03-1647</div>		17. INFORMANT ADDRESS <div style="text-align: center;">Herbert L. Wilker 8226 Watersedge Rd.</div>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9650 IMMEDIATE CAUSE (a) <u>Gunshot wound of Head (Handgun)</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a):					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY (approx.) HOUR A.M. MONTH DAY YEAR <div style="text-align: center;">5:30 PM 10 7 1982</div>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) <div style="text-align: center;">subject was shot</div>	
21d. INJURY OCCURRED WHILE <input checked="" type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) <div style="text-align: center;">Bar</div>		21f. LOCATION STREET CITY OR TOWN COUNTY STATE <div style="text-align: center;">10741 Pulaski Highway, Baltimore Co., Md.</div>	
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> .					
ACTUAL SIGNATURE <i>Dennis F. Smyth M.D.</i>		TITLE (SPECIFY) M.D. Assistant		DATE SIGNED 10-7-82	
EXAMINER'S NAME (TYPE OR PRINT) <div style="text-align: center;">Dennis F. Smyth, M.D.</div>		ADDRESS <div style="text-align: center;">111 Penn Street</div>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <div style="text-align: center;">Burial</div>		23b. DATE <div style="text-align: center;">10-9-82</div>		23c. NAME OF CEMETERY OR CREMATORY <div style="text-align: center;">Parkwood Cem.</div>	
23d. LOCATION CITY OR TOWN COUNTY STATE <div style="text-align: center;">Balto. Md.</div>		24. FUNERAL DIRECTOR NAME ADDRESS <div style="text-align: center;">John C. Miller Inc. 6415 Belair Rd.</div>		25a. DATE REC'D. BY REGISTRAR <div style="text-align: center;">OCT 11 1982</div>	
25b. REGISTRAR'S SIGNATURE <i>John J. Carick</i>					

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



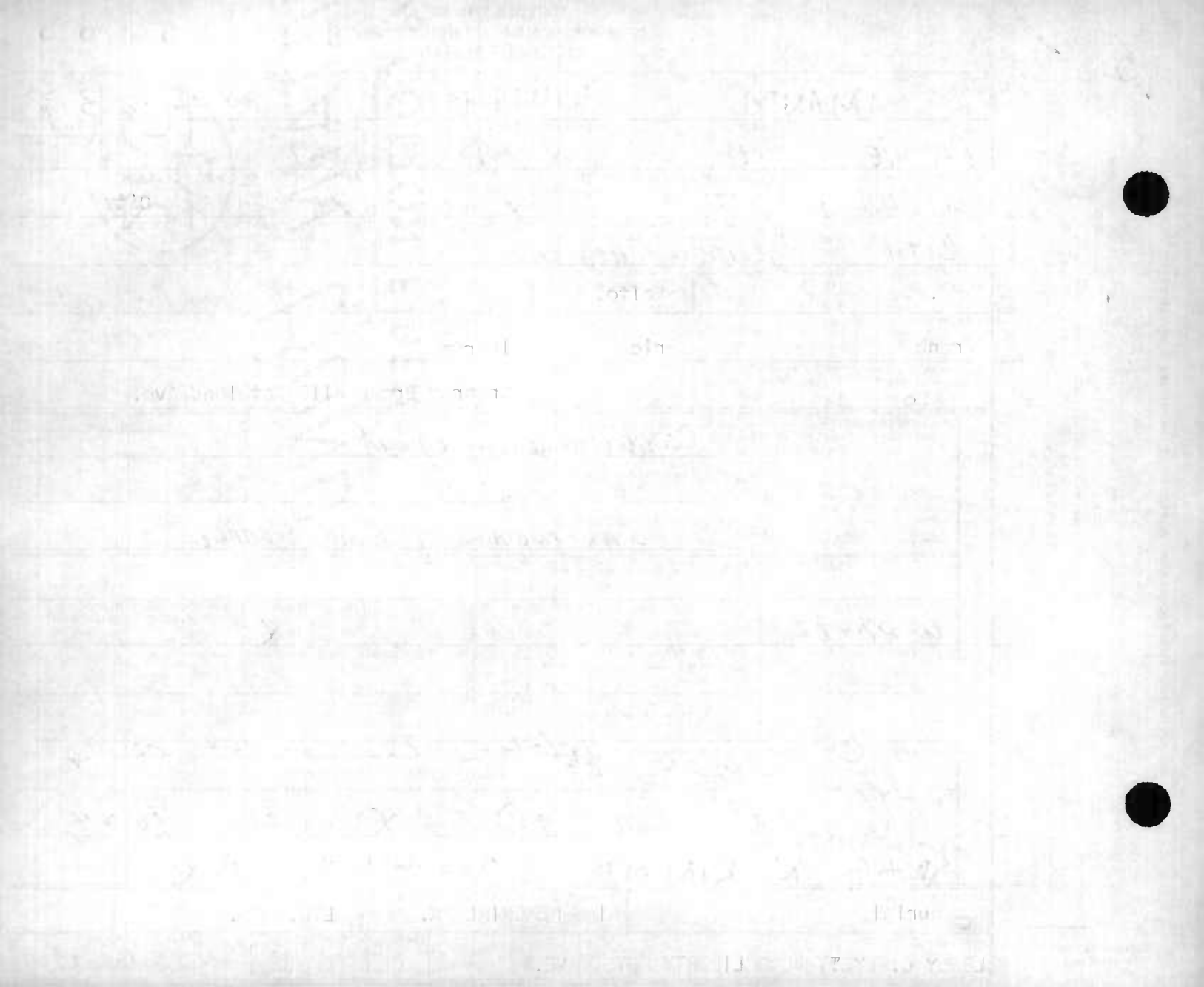
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 6 6

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) AMANDA		FIRST WILLIAMS		LAST		2a. DATE OF DEATH MONTH DAY YEAR 10 24 82		2b. HOUR 3:35 PM	
3. SEX FEMALE		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 8 31 15		6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) SOUTH CAROLINA		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE City MD.			
10. CITY OR TOWN OF DEATH CITY		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE MD.		13b. COUNTY		13c. CITY OR TOWN BALTO.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2640 HARLENU AVE	
14. FATHER'S NAME FIRST MIDDLE LAST Frank Brice				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alberta					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS Margaret Brown 4117 Kathland Ave.					
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiopulmonary arrest 1560 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) carcinoma of (c) carcinoma of Gall Bladder								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION 9-28-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (1) this hospital attended the deceased from 10-24-82 to 10-24-82 , that (1) (we) last saw the deceased alive on 10-24-82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did not) view the body after death.									
22b. SIGNATURE Kwang N. Kim		DEGREE MD		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED 10-24	
23a. PHYSICIAN'S NAME (TYPE OR PRINT) KWANG N. KIM-M.D.				23b. ADDRESS 730 Ashburton Ave					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY KING MEMORIAL PK.		23d. LOCATION CITY OR TOWN COUNTY STATE BALTO., MD.			
24. FUNERAL DIRECTOR NAME LEROY O. DYETT				ADDRESS 4600 LIBERTY HGTS. AVE.		25a. DATE REC'D. BY REGISTRAR OCT 26 1982		25b. REGISTRAR'S SIGNATURE John J. Connel	



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26367	
1. DECEASED NAME (TYPE OR PRINT) Bridget L. Williams						2a. DATE OF DEATH <input checked="" type="checkbox"/> KNOWN <input type="checkbox"/> ESTIMATED		MONTH DAY YEAR		2b. HOUR	
3. SEX female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR Aug. 11, 1962		6. AGE (IN YEARS LAST BIRTHDAY) 20 YRS.		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Balto., Md.				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 12 19 82	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.				10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5606 Haddon Avenue			
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY							
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 5606 Haddon Ave.			
14. FATHER'S NAME FIRST MIDDLE LAST Leon G. Williams				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen Neale							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO.				17. INFORMANT ADDRESS Helen Wyche 4112 Crawford Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 9654 IMMEDIATE CAUSE (a) Gunshot wounds of head DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR ? P.M. 10 12 19 82				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Subject shot			
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home				21f. LOCATION CITY OR TOWN STREET COUNTY STATE 5606 Haddon Ave. Balto. Md.			
22a. I certify that I took charge of the remains described above, held on death resulted from: <input type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE Thomas D. Smith				TITLE (SPECIFY) Deputy Chief				DATE SIGNED 10/13/82			
EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D.				ADDRESS 111 Penn St. Balto., MD.							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 10/16/82				23c. NAME OF CEMETERY OR CREMATORY New Cathedral Cem.			
23d. LOCATION CITY OR TOWN COUNTY STATE Balto., Md.				24. FUNERAL DIRECTOR LERoy O. DYETT 4600 Liberty Hgts. Ave.				25a. DATE REC'D. BY REGISTRAR OCT 15 1982 25b. REGISTRAR'S SIGNATURE John J. Smith			

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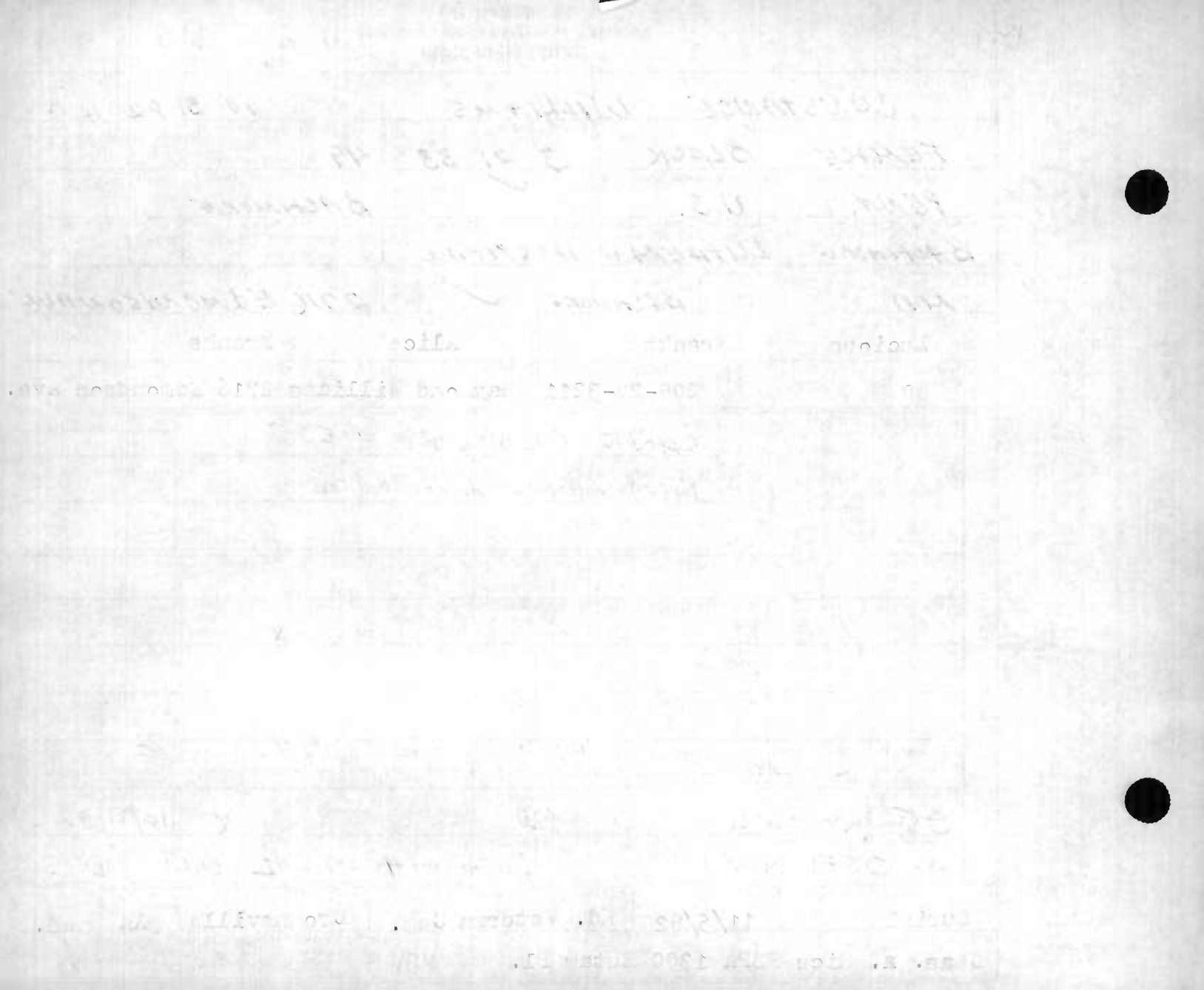
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 3 6 8			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) CONSTANCE WILLIAMS					2a. DATE OF DEATH MONTH DAY YEAR 10 31 82					2b. HOUR 10 P. M.			
3. SEX FEMALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 3 21 33		6. AGE (IN YEARS LAST BIRTHDAY) 49 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PENN.		7b. CITIZEN OF WHAT COUNTRY? U.S.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.							
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) LUTHERAN HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
13a. STATE MD		13b. COUNTY		13c. CITY OR TOWN BALTIMORE		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 2716 EDMONDSON AVE					
14. FATHER'S NAME FIRST MIDDLE LAST Lucious Franks					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Franks								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO				16b. SOCIAL SECURITY NO. 209-26-3211		17. INFORMANT ADDRESS Raymond Williams 2716 Edmondson Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIO-PULMONARY ARREST 4329 DUE TO, OR AS A CONSEQUENCE OF (b) INTRACRANIAL HEMORRHAGE DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: NO													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME STREET, FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 10/31/82 19 82 to 10/31 19 82 , that (I) (we) last saw the deceased alive on 10/31/82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE A. Osei-Wusu		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10/31/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) A-OSEI-WUSU				22e. ADDRESS LUTHERAN HOSPITAL BALTI. MD.									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11/5/82		23c. NAME OF CEMETERY OR CREMATORY Md. Veteran Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Crownsville AA Md.		23e. DATE REC'D. BY REGISTRAR NOV 3 1982					
24. FUNERAL DIRECTOR NAME Chas. A. Rice FSPA 1300 Eutaw Pl.				25. REGISTRAR'S SIGNATURE John J. Connel									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be joined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 6 3 6 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) Debornu B Williams				2a. DATE OF DEATH		2b. HOUR	
				MONTH DAY YEAR		MONTH DAY YEAR	
				10 5 82		11 15 PM	
3. SEX F		4. RACE B		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)	
				MONTH DAY YEAR		YRS MONTHS DAYS HOURS MIN.	
				2 24 61		21	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BALTIMORE		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University of Maryland Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13b. INSIDE CITY LIMITS?			
13a. STATE MD 13b. COUNTY City 13c. CITY OR TOWN BALT				YES <input type="checkbox"/> NO <input type="checkbox"/>			
14. FATHER'S NAME FIRST Louis R. MIDDLE Williams LAST				15. MOTHER'S MAIDEN NAME FIRST Shelley MIDDLE Williams LAST			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. 212-80-9401		17. INFORMANT JANET Lewis	
				ADDRESS 1628 Normal St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4239 IMMEDIATE CAUSE (a) Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) hypertension DUE TO, OR AS A CONSEQUENCE OF (c) pericardial infarction							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)							
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			
20a. AUTOPSY? Not performed YES <input type="checkbox"/> NO <input type="checkbox"/>				20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/5 , 19 82 , to 10/5 , 19 82 , that (I) (we) lost saw the deceased alive on 10/5 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE Judith Minkove				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/5/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Judith Minkove				22e. ADDRESS 22 S. GREENE ST.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-12-82		23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn		23d. LOCATION CITY OR TOWN COUNTY STATE Balto. Md.	
24. FUNERAL DIRECTOR NAME Charles A. Rice FHPA				ADDRESS 1300 Eutaw Place		25. REC'D. BY REGISTRAR Oct 8 1982	
				25. REGISTRAR'S SIGNATURE John J. Canine			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove signatures. Pages 1 and 2 should be filed with the registrar of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 3 7 0 REG. NO.	
1. FOR STATE REGISTRAR						2a. DATE OF DEATH		MONTH DAY YEAR		2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT)						FIRST MIDDLE LAST		Dorothy J. Williams		10/18/82 7:26 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		WHITE		MONTH DAY YEAR JUNE 3 1942		40 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		John Hopkins Hospital						ANSWERING SER.		PHONE	
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET ADDRESS		13f. ZIP CODE	
MD.		CARROLL		WESTMINSTER		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		113 LIBERTY		21157	
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME							
FIRST MIDDLE LAST WALTER ARSENAULT				FIRST MIDDLE LAST DOROTHY EDWARDSON							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT				ADDRESS			
NO		NONE		219-38-3651		DR. DANIEL WILLIAMS				13e	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4151 IMMEDIATE CAUSE (a) <u>cardiac arrest</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>pulmonary embolism</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART I OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <u>10/18</u> , 19 <u>82</u> , to <u>10/18</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>10/18</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>Drew Pardoll MD</u>						DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Drew Pardoll</u>						22e. ADDRESS <u>Johns Hopkins Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE					
CREMATION		10-20-82		SECURITY PROCESS		BALTIMORE BALT. MD.					
24. FUNERAL DIRECTOR <u>Robert Kyle Priths Jr. Westminster, Md.</u>						25a. DATE REC'D. BY REGISTRAR OCT 26 1982					
						25b. REGISTRAR'S SIGNATURE <u>John J. Canine</u>					

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 7 1

REG. NO.

1- FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT)		FIRST MIDDLE LAST FRANCES WILLIAMS		2a. DATE OF DEATH MONTH DAY YEAR OCT. 19, 1982		2b. HOUR 10:32 M	
3. SEX F		4. RACE B		5. DATE OF BIRTH MONTH DAY YEAR 4-2-01		6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION THE JOHNS HOPKINS HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Md		13b. COUNTY BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 467 Walton St	
14. FATHER'S NAME FIRST MIDDLE LAST William		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lucy Maddox		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO.	
17. INFORMANT Elissa Brown		ADDRESS 530 King Malcolm Ave					

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4039 Cardiorespiratory arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 min	
DUE TO, OR AS A CONSEQUENCE OF (b) gastrointestinal bleed		~ 4 months	
DUE TO, OR AS A CONSEQUENCE OF (c) chronic renal failure		years	

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: **hypertension**

19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR — P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —		21f. LOCATION STREET —		CITY OR TOWN —	
21g. COUNTY —		21h. STATE —		22a. I certify that (1) (this hospital) attended the deceased from 9/30 , 19 82 , to 10/19 , 19 82 , that (1) (we) last saw the deceased alive on 10/19 , 19 82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death.			
22b. SIGNATURE R A Lange M.D.		DEGREE —		ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED —	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) RA LANGE MD		22e. ADDRESS JOHNS HOPKINS					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/25/82		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem PA		23d. LOCATION CITY OR TOWN Balto	
23e. COUNTY Md		23f. STATE Md		24. FUNERAL DIRECTOR NAME Vernon R. Bailey		25a. DATE REC'D. BY REGISTRAR OCT 26 1982	
25b. ADDRESS 1348 N. Calhoun St		25c. REGISTRAR'S SIGNATURE John J. Connel					

MEMORANDUM

FOR THE RECORD

DATE: OCT. 1, 1964

TO: SAC, NEW YORK

FROM: SAC, NEW YORK

SUBJECT: [Illegible]

RE: [Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

[Illegible]

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 6 3 7 2	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT)			FIRST James			MIDDLE E			LAST Williams		
2. SEX male		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 9 14 60		6. AGE (IN YEARS) LAST BIRTHDAY 21 YRS		IF UNDER 1 YR. MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 9 30 19 82		7b. HOUR M 11:20
10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) University Hospital			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 9 30 19 82
13a. STATE S.C.			13b. COUNTY MrytleBeach			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS Rt. 2 Box 119 N. Mrytle Beach		
14. FATHER'S NAME FIRST MIDDLE LAST Robert Stevenson			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Shirley Williams			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. 247-21-3433		
17. INFORMANT Theodis Williams			ADDRESS Rt. 2 Box 119 N.			18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8147 Conditions, if any, which gave rise to immediate cause (b) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>					
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 8:05 PM 9/30/19 82			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) pedestrian struck by automobile					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway			21f. LOCATION STREET CITY OR TOWN Balto/Wash Parkway/North of Rt 895, Linthicum, AA County, MD					
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion											
ACTUAL SIGNATURE <i>[Signature]</i>			TITLE (SPECIFY) M.D. Assistant			MEDICAL EXAMINER			DATE SIGNED 10/1/82		
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.			ADDRESS 111 Penn Street, Balto., MD 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/11/82			23c. NAME OF CEMETERY OR CREMATORY St. Joseph Cemetery			23d. LOCATION CITY OR TOWN mrytle Beach		
24. FUNERAL DIRECTOR NAME William C. March F/H 1101 E. North Avenue			ADDRESS 1101 E. North Avenue			25a. DATE REC'D. BY REGISTRAR OCT 4 1982			25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>		



RECEIVED MAY 10 1910



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be placed with 52 hours after death. Pages 3 and 4 should be placed with the body after death.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination must be performed.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 6 3 7 3 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST Joshua Edward Williams				MONTH DAY YEAR 10 1 82			
3. SEX				2b. HOUR			
male				M			
4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR	
Black		MONTH DAY YEAR 2 22 05		77 YRS.		IF UNDER 24 HRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			
Maryland		USA		9. BALTIMORE CITY OR COUNTY OF DEATH			
Baltimore		Bon Secours Hospital		Baltimore City, MD.			
10. CITY OR TOWN OF DEATH				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			
Baltimore							
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12b. KIND OF BUSINESS OR INDUSTRY			
Bon Secours Hospital							
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland		Ba-timore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13f. STREET ADDRESS			
FIRST MIDDLE LAST Joshua Williams		FIRST MIDDLE LAST Octavia Garnett		2804 Boarmon Avenue			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS			
No		217-09-1497		Margaret Fleet 2804 Boarman Ave 21215			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) MYOCARDIAL INFARCTION							
4100 DUE TO, OR AS A CONSEQUENCE OF							
(b) ARTERIO-SCLEROTIC C-V DIS.							
DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?	
				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
		HOUR A.M. MONTH DAY YEAR P.M. 19					
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION			
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 4/1/80 to 10/1/82, that (I) (we) last saw the deceased alive on 8/1/82, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE				DEGREE		22c. DATE SIGNED	
				MD			
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS			
J. BRAXTON				S. BRAXTON, JR., MD 4432 PARK HEIGHTS AVE BALTIMORE, MD			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION	
BURIAL		10/7/82		King Memorial Pk.		Baltimore Md.	
24. FUNERAL DIRECTOR NAME				25a. DATE REC'D. BY REGISTRAR			
Wm. C. march F/H 1101 E. North Ac				OCT 6 1982			
				25b. REGISTRAR'S SIGNATURE			
				John J. Conner			

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THE UNIVERSITY OF MICHIGAN

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

item 17 #G573 11/5/82 ph

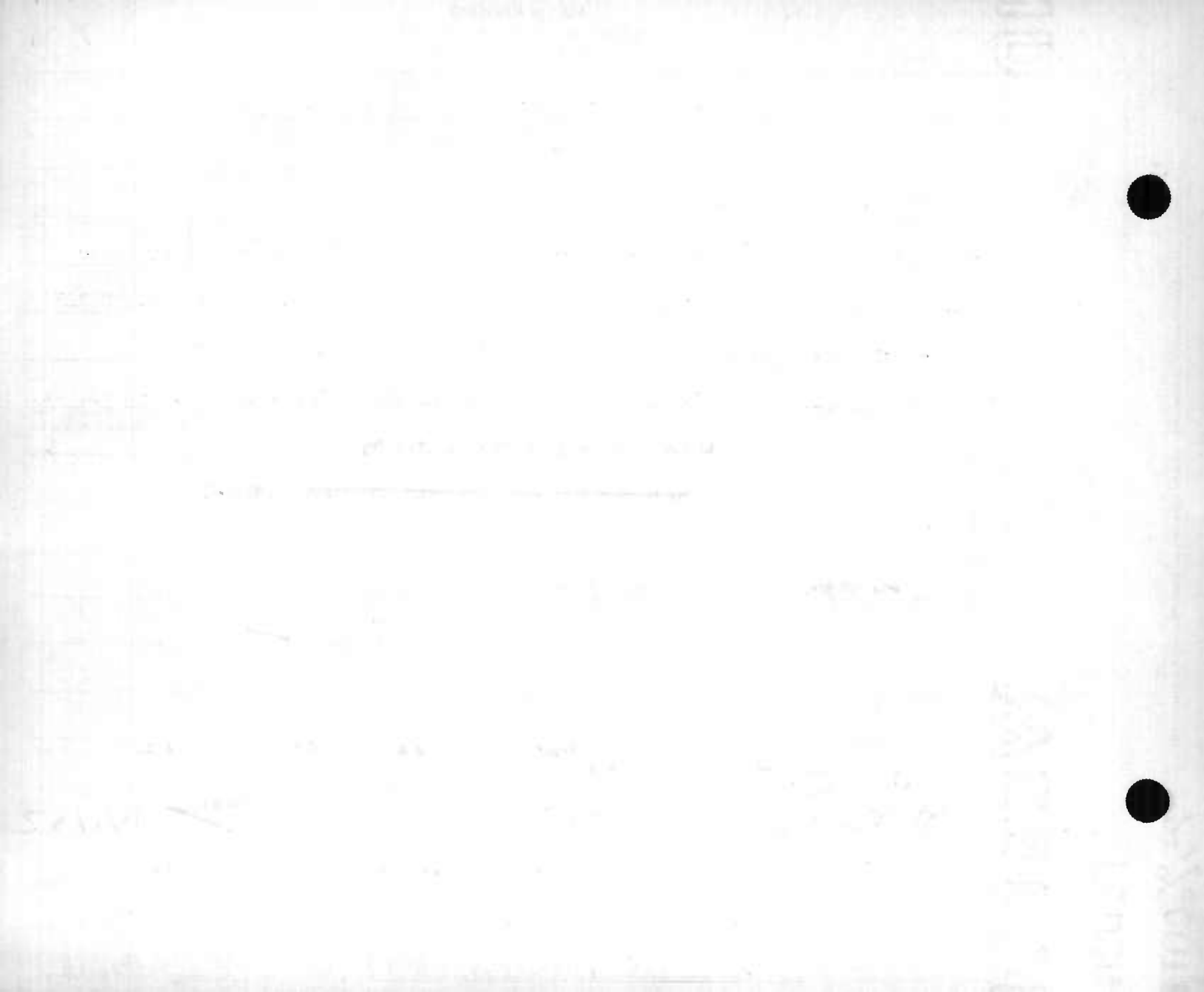
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 7 4

1- STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) THOMAS O. WILLIAMS			2a. DATE OF DEATH MONTH DAY YEAR 10-31-82			2b. HOUR M			
3 SEX MALE		4 RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR Sept 26 1922		6 AGE (IN YEARS LAST BIRTHDAY) 60 YRS		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Harford Co. Md.		9b. CITIZEN OF WHAT COUNTRY? U.S.A.		9. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City MD.			
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1628 W. Lanvale St.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Stock clerk		12b. KIND OF BUSINESS OR INDUSTRY warehouse	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md.			13b. COUNTY Balto		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 1628 W. Lanvale St. 21217		
14. FATHER'S NAME FIRST MIDDLE LAST Joshua E. Williams			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary M. Carey						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW1 217 18 6971		17. INFORMANT ADDRESS Mrs. Balnche Williams 1628 W. Lanvale St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Unwitnessed sudden death.</u> 1629 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>metastatic carcinoma of lung ERROR</u> (c) <u>metastatic carcinoma of lung</u> DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>metastatic carcinoma of lung</u>									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> 19 <u>82</u> , to <u>Oct</u> 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>Sept</u> 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>Susan K. Ferrand</u>			DEGREE MD			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>11/1/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Susan K. Ferrand</u>			22e. ADDRESS <u>Johns Hopkins Hospital</u>						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>			23b. DATE <u>11/6/82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>BALTO. Md.</u>		
24. FUNERAL DIRECTOR NAME <u>JAS. A. MORTON & SONS</u>			ADDRESS <u>1701 LAURENS</u>			25a. DATE REC'D. BY REGISTRAR <u>NOV 1 1982</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Carver</u>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

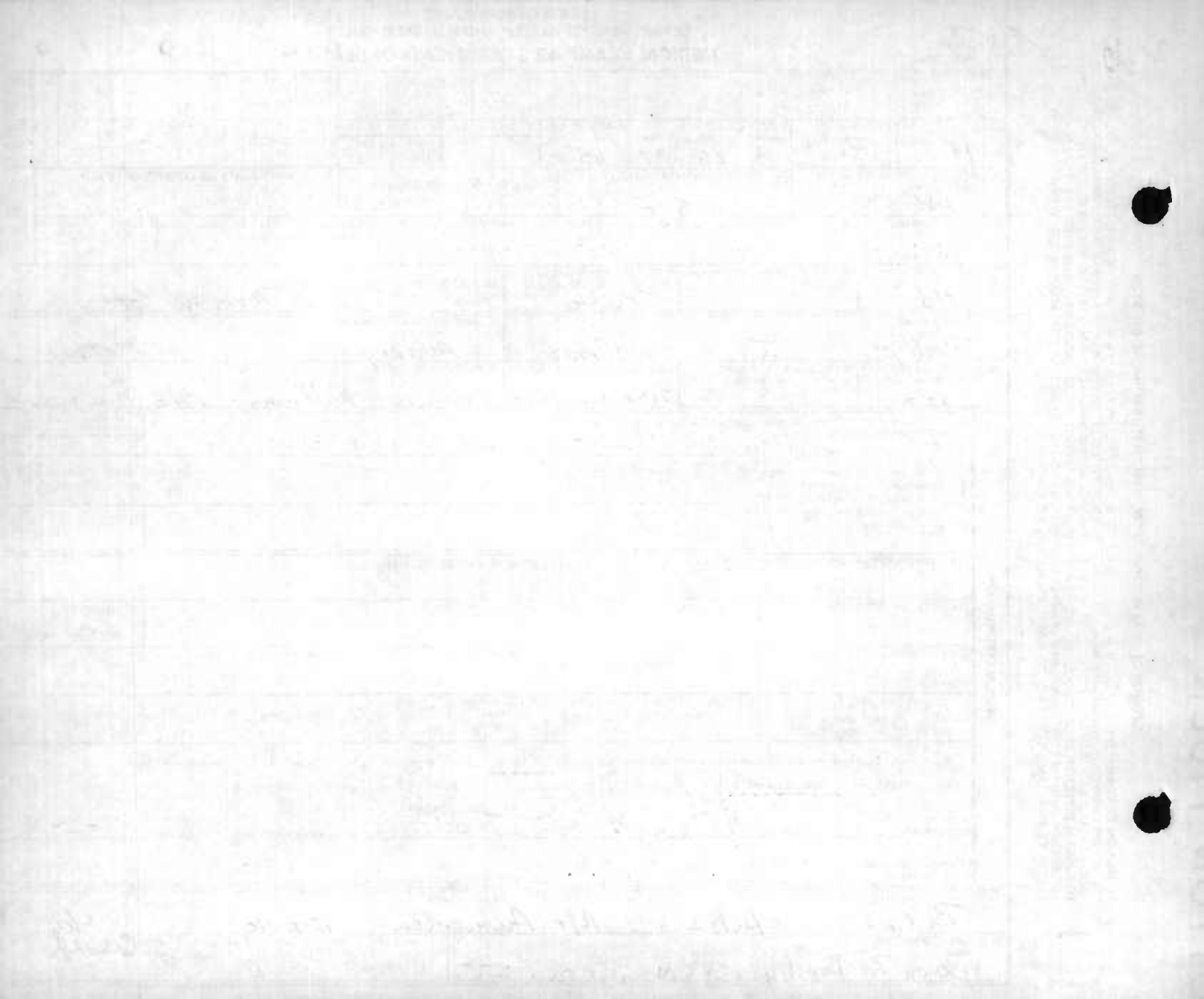
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified to autopsify.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH									
1. FOR STATE REGISTRAR		REG. NO. 82 26375							
1. DECEASED NAME (TYPE OR PRINT)			2a. DATE OF DEATH			MONTH DAY YEAR			2b. HOUR
Viola			Williams			9-23-82			5:45 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. UNDER 1 YEAR	
Female		Col. ✓		3-1-1906		76		MONTHS DAYS HOURS MINS	
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		9. CITIZEN OF WHAT COUNTRY?		10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		11. BALTIMORE CITY OR COUNTY OF DEATH			
Gnd		U.S.A				City			
12. CITY OR TOWN OF DEATH		13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH PLACE, GIVE STREET ADDRESS)		14. USUAL OCCUPATION (TYPE OF WORK FOR MAJOR PART OF WORKING LIFE)		15. KIND OF BUSINESS OR INDUSTRY			
Balt.		Lutheran Hosp		Domestic					
16. USUAL RESIDENCE (HUSBAND'S HOME OR OTHER INSTITUTION; GIVE RESIDENCE BEFORE ADMISSION)		17. STATE		18. CITY OR TOWN		19. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20. STREET ADDRESS	
Maryland		Balt.				YES		606 Claymont Ave	
21. FATHER'S NAME (LAST FIRST MIDDLE)		22. MOTHER'S MAIDEN NAME (LAST FIRST MIDDLE)		23. ADDRESS					
Henry Blackston		Emma Blackston		606 Claymont Ave					
24. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		25. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		26. INFORMANT		27. ADDRESS			
NO		212-34-8555		Mrs. Emma Wilkins		606 Claymont Ave			
28. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4360 CVA									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
29. DATE OF OPERATION			30. CONDITION FOR WHICH OPERATION WAS PERFORMED			31. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		32. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
33. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			34. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			35. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1; DEPART 2)			
36. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT HOME <input type="checkbox"/>			37. PLACE OF INJURY (AT HOME-STREET, FACTORY, OFFICE, FARM, ETC.)			38. LOCATION STREET CITY OR TOWN COUNTY STATE			
39. I certify that in this hospital attended the deceased from 9/27 19 82 to 9/23 19 82, that (I) (we) last saw the deceased alive on 9/23 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
40. SIGNATURE			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		41. DATE SIGNED	
Henry S. Sacerie								9/23/82	
42. PHYSICIAN'S NAME (TYPE OR PRINT)			43. ADDRESS			44. DATE REC'D. BY REGISTRAR			
Henry S. Sacerie			Lutheran Hospital Balt. Md.			OCT 4 - 1982			
45. BURIAL, CREMATION, REMOVAL (TYPE)			46. DATE			47. NAME OF CEMETERY OR CREMATORY		48. LOCATION CITY OR TOWN COUNTY STATE	
Burial			9-28-82			Mt. Auburn Cem		Balt. Md.	
49. FUNERAL DIRECTOR NAME			ADDRESS			50. REGISTRAR'S SIGNATURE			
Joseph L. Russ			2222 W. North Ave			John J. Carver			

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26376	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Vernon P. Williams						2a. DATE KNOWN OF DEATH ESTIMATED MONTH DAY YEAR 10 22 1982			2b. HOUR M 6:19		
3. SEX M	4. RACE B	5. DATE OF BIRTH MONTH DAY YEAR 2 18 37	6. AGE (IN YEARS LAST BIRTHDAY) 45 YRS.	IF UNDER 1 YR. MONTHS DAYS HOURS MIN.	IF UNDER 24 HRS.	2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 22 1982			2d. HOUR M 8:19		
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Laurens & Division Streets				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. STATE Md						13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1809 Division St											
14. FATHER'S NAME FIRST MIDDLE LAST Phillip J. Williams						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Audrey Matthews					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) yes			16b. SOCIAL SECURITY NO. 215-32-7593			17. INFORMANT Francis Williams			ADDRESS 1913 Division St		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). Obesity											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?								
19c. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Dennis F. Smyth, M.D.						TITLE (SPECIFY) Assistant			MEDICAL EXAMINER		
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D.						ADDRESS 111 Penn Street			DATE SIGNED 10-22-82		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/26/82			23c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem			23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md		
24. FUNERAL DIRECTOR NAME Vernon R. Bailey						ADDRESS 1548 N. Calhoun St			25a. DATE REC'D. BY REGISTRAR OCT 26 1982		
						25b. REGISTRAR'S SIGNATURE John J. Smith					



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 7 7
REG. NO.

1. FOR STATE REGISTRAR		1. DECEASED NAME (TYPE OR PRINT)		FIRST CURTIS	MIDDLE E.	LAST WILLIS SR.	2a. DATE OF DEATH MONTH DAY YEAR 10 19 82	2b. HOUR 9:45A M
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH DAY YEAR May 5 1896		6. AGE (IN YEARS LAST BIRTHDAY) 86 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS		8. IF UNDER 24 HRS HOURS MIN.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.	7b. CITIZEN OF WHAT COUNTRY? U.S.A.	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.		10. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		
10. CITY OR TOWN OF DEATH BALTIMORE	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) VAMC LOCH RAVEN BLVD. BALTO. MD		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Mechanic		12b. KIND OF BUSINESS OR INDUSTRY TANKS			
13a. STATE Md.	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET ADDRESS 115 E. Clement St. (21230)				
14. FATHER'S NAME FIRST MIDDLE LAST Increase Willis		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Georgia						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes		16b. SOCIAL SECURITY NO. 214 03 4255		17. INFORMANT ADDRESS Mary R. Willis, (same as 13e)				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Collapse</u> 5070 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Chronic Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Aspiration Pneumonia</u> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <u>October 7</u> , 19 <u>82</u> , to <u>October 19</u> , 19 <u>82</u> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <u>October 19</u> , 19 <u>82</u> , and that in <input checked="" type="checkbox"/> (my) (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.								
22b. SIGNATURE <u>Thomas E. Lipin</u>		DEGREE MD		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/19		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Thomas E. Lipin		22e. ADDRESS 3900 Loch Raven Blvd. Balto. Md 21218						
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial	23b. DATE 10/22/82	23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie Md.				
24. FUNERAL DIRECTOR NAME ADDRESS George J. Gonce F.H. 4001 Ritchie Hgwy.		25a. DATE REC'D. BY REGISTRAR OCT 25 1982		25b. REGISTRAR'S SIGNATURE <u>John J. Conner</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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862 863 864 865 866 867 868 869 870 871 872 873 874 875 876 877 878 879 880 881 882 883 884 885 886 887 888 889 890 891 892 893 894 895 896 897 898 899 900 901 902 903 904 905 906 907 908 909 910 911 912 913 914 915 916 917 918 919 920 921 922 923 924 925 926 927 928 929 930 931 932 933 934 935 936 937 938 939 940 941 942 943 944 945 946 947 948 949 950 951 952 953 954 955 956 957 958 959 960 961 962 963 964 965 966 967 968 969 970 971 972 973 974 975 976 977 978 979 980 981 982 983 984 985 986 987 988 989 990 991 992 993 994 995 996 997 998 999 1000 1001 1002 1003 1004 1005 1006 1007 1008 1009 1010 1011 1012 1013 1014 1015 1016 1017 1018 1019 1020 1021 1022 1023 1024 1025 1026 1027 1028 1029 1030 1031 1032 1033 1034 1035 1036 1037 1038 1039 1040 1041 1042 1043 1044 1045 1046 1047 1048 1049 1050 1051 1052 1053 1054 1055 1056 1057 1058 1059 1060 1061 1062 1063 1064 1065 1066 1067 1068 1069 1070 1071 1072 1073 1074 1075 1076 1077 1078 1079 1080 1081 1082 1083 1084 1085 1086 1087 1088 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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL HOME. FOR PAGE 4, SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 2 6 3 7 8	
1. FOR STATE REGISTRAR											
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Donald Wilson										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MATED <input type="checkbox"/> MONTH DAY YEAR 10 5 19 82	
3. SEX male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 2 30 45	6. AGE (IN YEARS) (LAST BIRTHDAY) 37 YRS.	IF UNDER 1 YR. MONTHS DAYS	IF UNDER 24 HRS. HOURS MIN	7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 5 19 82		2d. HOUR 2:30			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City		AM			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 502 E. 21st Street				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY			
USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)											
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 502 E. 21st. Street 21218			
14. FATHER'S NAME FIRST MIDDLE LAST Henry Wilson				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mable Johnson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No				16b. SOCIAL SECURITY NO. N/A		17. INFORMANT ADDRESS Marietta Wilson 610 Gold St. 21217					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Smoke Inhalation</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:47 AM 10/5 1982		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) housefire					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 502 E. 21st Street, Balto. MD					
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE <u>H. R. Guard</u>				TITLE (SPECIFY) M.D. Assistant				MEDICAL EXAMINER DATE SIGNED 10/5/82			
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.				ADDRESS 111 Penn St. Balto., MD							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL				23b. DATE 10/9/82		23c. NAME OF CEMETERY OR CREMATORY Mount Auburn Cem.		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md			
24. FUNERAL DIRECTOR NAME Wm. C. March F/h				ADDRESS 1101 E. north Avenue		DATE RECD. BY REGISTRAR OCT 6 1982		25a. REGISTRAR'S SIGNATURE <u>John J. Smith</u>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 4 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 6 3 7 9 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) JESSIE L. WILSON				2a. DATE OF DEATH MONTH 10 DAY 13 YEAR 82		2b. HOUR 1040 AM	
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH 7 DAY 28 YEAR 04		6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)	
13a. STATE Maryland				13b. COUNTY		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST James MIDDLE Wilson LAST Wilson				15. MOTHER'S MAIDEN NAME FIRST Juoy MIDDLE Henderson LAST Henderson			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-07-3203		17. INFORMANT ADDRESS Henrietta Kenny 4520 Fair Fax Rd			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) HEART FAILURE 4100 DUE TO, OR AS A CONSEQUENCE OF (b) MYOCARDIAL INFARTION Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) ATHEROSCLEROTIC HEART DISEASE							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) PULMONARY EDEMA							
19a. DATE OF OPERATION NONE		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) NONE			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (a) this hospital attended the deceased from 9/26 , 19 82 , to 10/13 , 19 82 , that (b) (we) last saw the deceased alive on 10/13 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, and (we) (did) (not) view the body after death.							
22b. SIGNATURE David Leichtling				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/13/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DAVID LEICHTLING, M.D.				22e. ADDRESS 201 E. University Pkwy. Balto. 21218			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/16/82		23c. NAME OF CEMETERY OR CREMATORY Arbutus Mem. Pk.		23d. LOCATION CITY OR TOWN Arbutus COUNTY Md. STATE Md.	
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. north Ave ADDRESS				25a. DATE REC'D. BY REGISTRAR OCT 18 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked as shown, any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 8 0

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) RANDOLPH Wm. WILSON			2a. DATE OF DEATH MONTH DAY YEAR 10 14 82			2b. HOUR 3:00 <small>AM</small>	
3. SEX Male	4. RACE white	5. DATE OF BIRTH MONTH DAY YEAR 5 11 12		6. AGE (IN YEARS LAST BIRTHDAY) 70		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. 70 YRS.	
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) South Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Balto. City MD.	
10. CITY OR TOWN OF DEATH Balto. Md.		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Mersey Hospital -		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Bar keep		12b. KIND OF BUSINESS OR INDUSTRY Bar owner	
13a. STATE Md.				13b. COUNTY Balto.		13c. CITY OR TOWN Balto.	
14. FATHER'S NAME FIRST MIDDLE LAST John Foerlschbeck				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Fohrkold			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES		16b. SOCIAL SECURITY NO. 217-14-3433		17. INFORMANT ADDRESS Jessie E. Willis 906 S. Kenwood Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ASPIRATION PNEUMONIA 3352 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) LOWER MOTOR NEURON SYNDROME DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMA OF THE PROSTATE APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 5 days 5 months 4 1/2 years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) SP IMPLANTATION OF CARDIAC PACEMAKER FOR 1976							
19a. DATE OF OPERATION 8/30/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED STOKES-ADAMS SYNDROME		20. IN THIS CASE, WERE ANY INSTRUMENTS USED IN THE DIAGNOSIS OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 8/30/82		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 10/14/82			
22a. I certify that (I (this hospital) attended the deceased from 10/14/82 to 10/14/82 that (I (we) last saw the deceased alive on 10/14/82 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I (we) (did) did not) view the body after death.							
22b. SIGNATURE Newton C. Sun				DEGREE MD		22c. DATE SIGNED 10/14/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NEWSON C. Sun, MD		22e. ADDRESS 307 ST. PAUL PLACE BALTIMORE MD 21205					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation		23b. DATE 10/15/1982		23c. NAME OF CEMETERY OR CREMATORY Green Mount Crematory		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME Walter Brooks Bradley Inc. Balto., Md.				25a. DATE REC'D. BY REGISTRAR OCT 18 1982		25b. REGISTRAR'S SIGNATURE Jan J. Conner	

MADE IN U.S.A. 100% COTTON



Handwritten notes and text, mostly illegible due to fading and bleed-through. Some visible words include "100% COTTON", "MADE IN U.S.A.", and "100%".

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

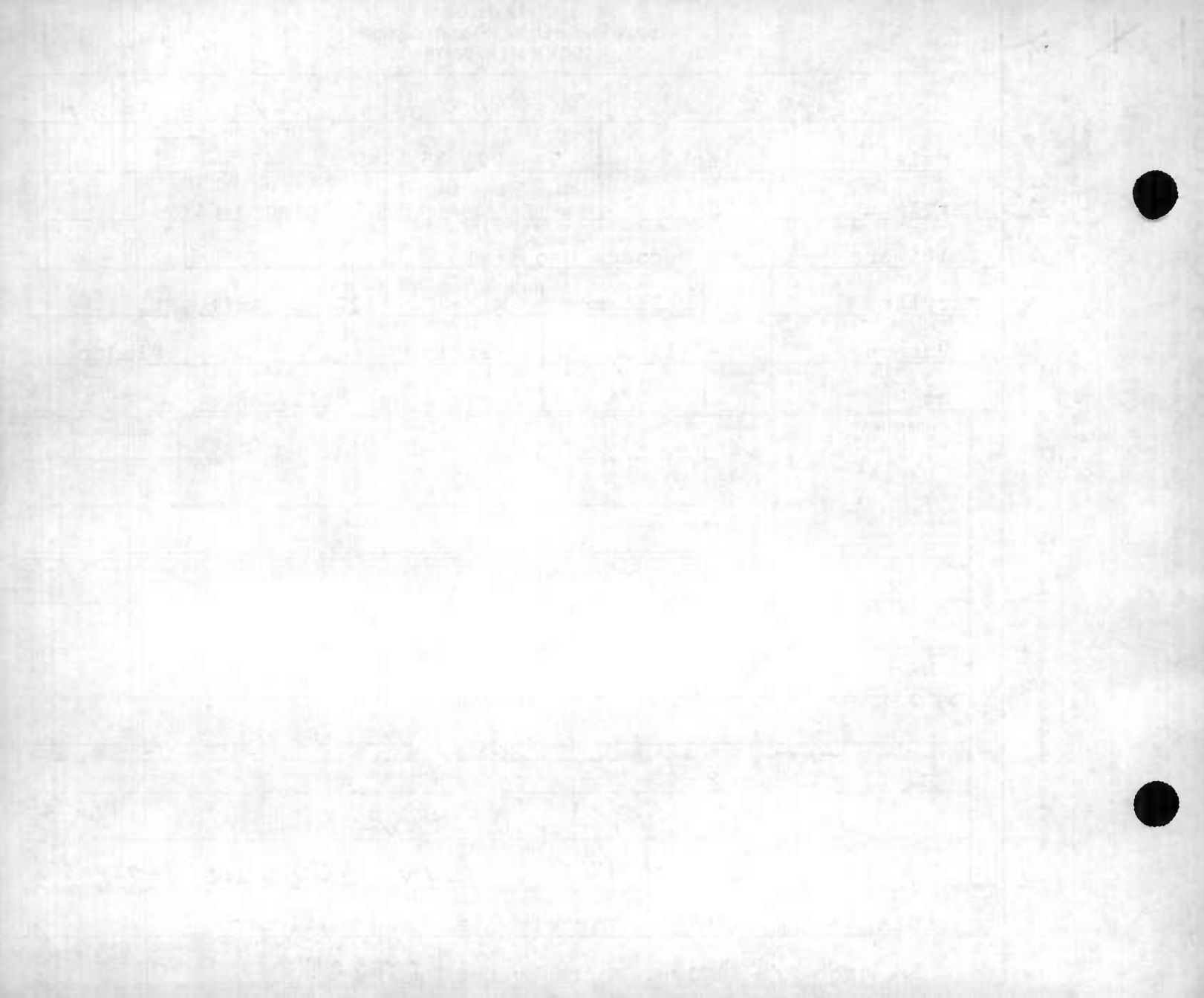
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified for autopsy.

DHMH-16 50M 1/81
(VRA 15, 4)

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH		8 2 2 6 3 8 1	
1. FOR STATE REGISTRAR		REG. NO.	
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST VERNON WILSON Jr		2a. DATE OF DEATH MONTH DAY YEAR 2b. HOUR 10 12 82 11 A M	
3. SEX male	4. RACE Black	5. DATE OF BIRTH MONTH DAY YEAR 5 29 35	
6. AGE (IN YEARS LAST BIRTHDAY) 47 YRS	7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland	8. CITIZEN OF WHAT COUNTRY? USA	9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD
10. CITY OR TOWN OF DEATH Baltimore	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Bon Secours Hospital	12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) 12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland	13b. COUNTY	13c. CITY OR TOWN Baltimore	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
14. FATHER'S NAME FIRST MIDDLE LAST Vernon Wilson Sr	15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Hattie Pinder	16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No	
16b. SOCIAL SECURITY NO. N/A	17. INFORMANT Doris Jones	ADDRESS 3119 Bakre	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>CA of lung metastasis</u> 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)	
21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	
21f. LOCATION STREET CITY OR TOWN COUNTY STATE		21g. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from <u>10/12/82</u> to <u>10/12/82</u> , that (I) (we) last saw the deceased alive on <u>10/12/82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.			
22b. SIGNATURE KUANG-YEN HUANG		22c. DATE SIGNED 10/13/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) KUANG-YEN HUANG		22e. ADDRESS BON Secours Hospital	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/16/82	23c. NAME OF CEMETERY OR CREMATORY Eastview Mem Pk.
23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.		24. FUNERAL DIRECTOR NAME ADDRESS Wm. c. March F/H 1101 e. North avenue	
25a. DATE REC'D. BY REGISTRAR OCT 14 1982		25b. REGISTRAR'S SIGNATURE John J. Larrick	

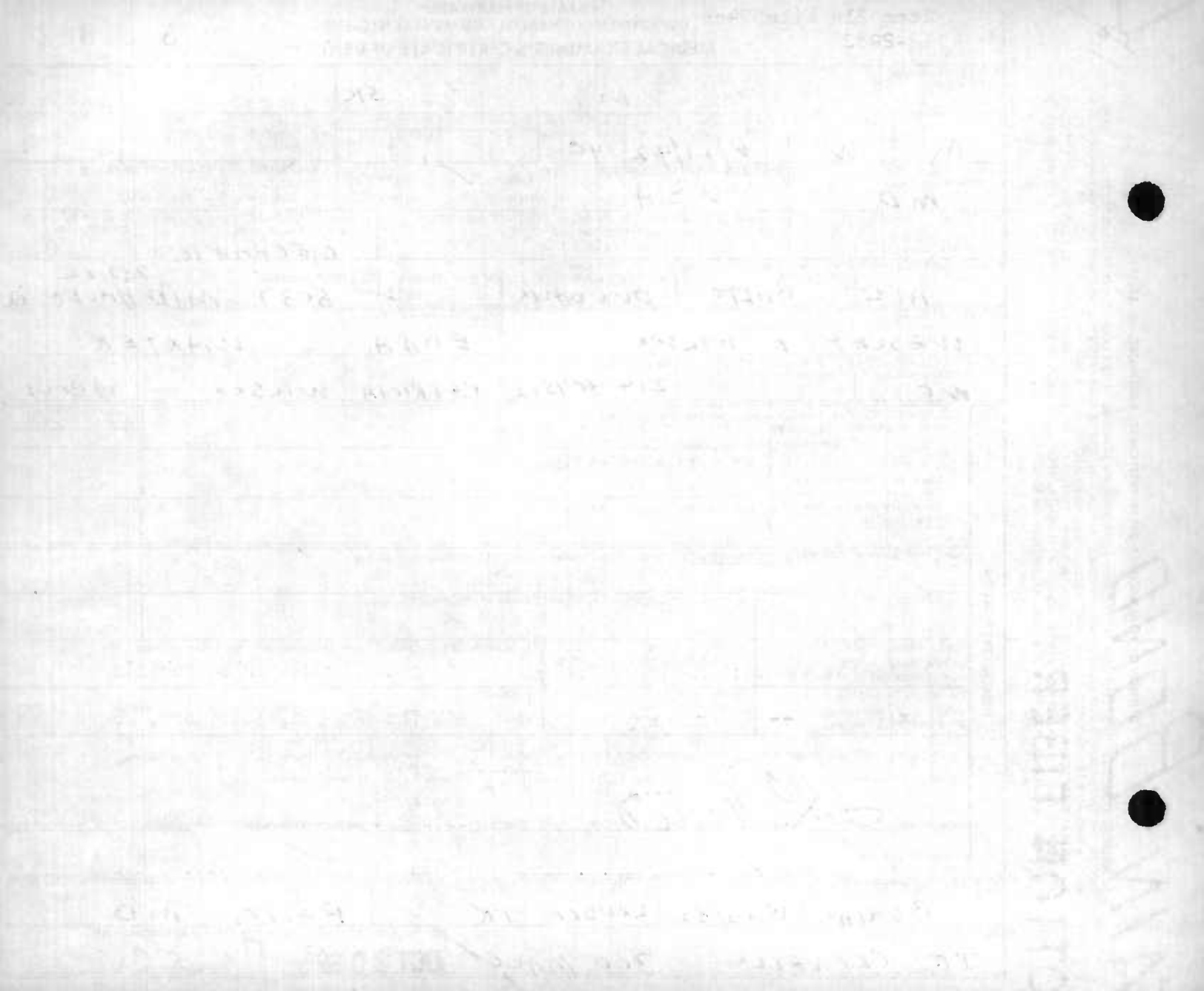
MEDICAL CERTIFICATION



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 12 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND. 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____
DHMH - 17
(VR A15 ME (5))
20M 4/82

Item 21d Film 574cn										STATE OF MARYLAND																			
1- FOR STATE REGISTRAR 12-2082										DEPARTMENT OF HEALTH AND MENTAL HYGIENE																			
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 2 2 6 3 8 2																			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Walter M. Wilson SR										2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 10 19 82 2b. HOUR 1:35 PM																			
3. SEX M		4. RACE W		5. DATE OF BIRTH MONTH DAY YEAR 6/21/42		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.		IF UNDER 1 YR. MONTHS DAYS HOURS MIN.		IF UNDER 24 HRS. MONTHS DAYS HOURS MIN.		2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 10 19 82 2d. HOUR 1:35 PM																	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD				7b. CITIZEN OF WHAT COUNTRY? USA				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD																	
10. CITY OR TOWN OF DEATH Baltimore				11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 5900 The Alameda				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MECHANIC				12b. KIND OF BUSINESS OR INDUSTRY																	
13a. STATE MD 13b. COUNTY BALTO 13c. CITY OR TOWN DUNDACK										13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS 2122 8037 MID HAVEN A																			
14. FATHER'S NAME FIRST MIDDLE LAST WESLEY E WILSON										15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST EDNA WAXTER																			
16. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO										16b. SOCIAL SECURITY NO. 214 409512																			
17. INFORMANT ADDRESS PATRICIA WILSON ABOLZ																													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Multiple injuries 8120 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																													
19a. DATE OF OPERATION										19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH										21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:30P.M. 10/19 82										21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) driver in auto struck parked vehicle									
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) roadway										21f. LOCATION STREET CITY OR TOWN COUNTY STATE 5800 Blk The Alameda, Baltimore, MD									
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																			
ACTUAL SIGNATURE [Signature]										TITLE (SPECIFY) M.D. Assistant MEDICAL EXAMINER										DATE SIGNED 10/20/82									
EXAMINER'S NAME (TYPE OR PRINT) Hormez R. Guard, M.D.										ADDRESS 111 Penn Street, Balto. MD 21201																			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL										23b. DATE 10/23/82										23c. NAME OF CEMETERY OR CREMATORY LOUDON PK									
23d. LOCATION CITY OR TOWN COUNTY STATE BALTO. MD																													
24. FUNERAL DIRECTOR NAME J.G. CONNELLY ADDRESS 300 MACE										25a. DATE REC'D. BY REGISTRAR OCT 20 1982										25b. REGISTRAR'S SIGNATURE [Signature]									



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				REG. NO. 8 2 2 6 3 8 3			
1. FOR STATE REGISTRAR				2a. DATE OF DEATH MONTH DAY YEAR 10 6 82			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Sharon Lee Winbush				2b. HOUR 11:28 PM			
3 SEX Female		4 RACE White		5 DATE OF BIRTH MONTH DAY YEAR 11 16 48		6 AGE (IN YEARS LAST BIRTHDAY) 33 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10 CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Baltimore General Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sales		12b. KIND OF BUSINESS OR INDUSTRY self employed	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Md 13c. COUNTY A.A. 13d. CITY OR TOWN Glen Burnie 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13f. STREET ADDRESS 26 Steven Rd. 21061							
14. FATHER'S NAME FIRST MIDDLE LAST Albert Templeton		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dorothy Hood					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. 216-48-9026		17. INFORMANT Albert Templeton same as 13			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 1809 IMMEDIATE CAUSE (a) Cardio Respiratory Arrest DUE TO, OR AS A CONSEQUENCE OF (b) trauma DUE TO, OR AS A CONSEQUENCE OF (c) Motor Vehicle Cerebral Circulation to brain				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from 10/6/82, 19 82, to 10/6/82, 19 82, that (I) (we) lost saw the deceased alive on 10/6/82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE [Signature] MD		DEGREE		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/7/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Edwin E. Pagan		22e. ADDRESS 3001 South Howard St Baltimore Md.					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 11 Oct. 82		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem. Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. MD.	
24. FUNERAL DIRECTOR NAME James S. Kirkley F.H.		ADDRESS Glen Burnie MD.		25a. DATE REC'D. BY REGISTRAR OCT 13 1982		25b. REGISTRAR'S SIGNATURE [Signature]	

BP



CH
12
12

100% C.D. 1200

100

100% C.D. 1200



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to the scene.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 6 3 8 4			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Elizabeth WINSTON				2a. DATE OF DEATH MONTH DAY YEAR October 24, 1982			
2b. HOUR 12:07A		3. SEX Female		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 3 31 07	
6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS.		7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City				10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Maryland General Hospital	
12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)				12b. KIND OF BUSINESS OR INDUSTRY			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET ADDRESS 1215 W. Saratoga St.				14. FATHER'S NAME FIRST MIDDLE LAST Earl Smith		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 213-36-5462		17. INFORMANT ADDRESS Elizabeth Allen 505 Archer St. 21230			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypotension 3482 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Probable Sepsis DUE TO, OR AS A CONSEQUENCE OF (c) Unconsciousness Secondary to Increased Intracranial Pressure							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH one day ten days 18 days
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that XX (this hospital) attended the deceased from October 6, 1982 to October 24, 1982 that XX (we) lost saw the deceased alive on October 24, 1982 , and that in XX (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (the) (post) (mortem) (exam) (the) (body) (after) (death)							
22b. SIGNATURE S. Maurer M.D. DEGREE				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/24/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. Maurer, M. D.				22e. ADDRESS c/o Maryland General Hospital			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/29/82		23c. NAME OF CEMETERY OR CREMATORY Mount Zion Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Co. Md.	
24. FUNERAL DIRECTOR NAME Wm. c. March F/XH 1101 E, North Avenue				25a. DATE REC'D. BY REGISTRAR OCT 27 1982 25b. REGISTRAR'S SIGNATURE John J. Carver			

STATE OF MARYLAND

DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 8 5

REG. NO.

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) ANGELA DAWN WISE			2a. DATE OF DEATH MONTH DAY YEAR 10 23 82		2b. HOUR 4:15 P.M.
3. SEX F	4. RACE W	5. DATE OF BIRTH MONTH DAY YEAR 9 10 82		6. AGE (IN YEARS LAST BIRTHDAY) 1/12 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore MD.			10. CITY OR TOWN OF DEATH BALTIMORE		
11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST AGNES HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) —		12b. KIND OF BUSINESS OR INDUSTRY —
13a. STATE MD		13b. COUNTY BALTO.	13c. CITY OR TOWN BALTO	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST MICHAEL STUART WISE		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST TERRI LYNN McMILLAN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) —		16b. SOCIAL SECURITY NO. —		17. INFORMANT ADDRESS MICHAEL WISE SANFORD AVE 159	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 7580 Congenital Heart Disease DUE TO, OR AS A CONSEQUENCE OF (b) A-V canal DUE TO, OR AS A CONSEQUENCE OF (c) Down's Syndrome		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Congenital urethral obstruction & hydronephrosis	
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19a. DATE OF OPERATION 10/19/82	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) —	21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) —	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK —	21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) —	21f. LOCATION STREET CITY OR TOWN COUNTY STATE —	
22a. I certify that (I) (this hospital) attended the deceased from 10/19/82 to 10/23/82 , that (I) (we) last saw the deceased alive on 10/23/82 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death.			
22b. SIGNATURE William J. Hicken MD		22c. DATE SIGNED 10/24/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wm. J. HICKEN		22e. ADDRESS ST. AGNES HOSPITAL	

23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL	23b. DATE 10/26/82	23c. NAME OF CEMETERY OR CREMATORY LAKEVIEW	23d. LOCATION CITY OR TOWN COUNTY STATE SYKESVILLE MD
24. FUNERAL DIRECTOR NAME ADDRESS WEBER FUNERAL HOME		25a. REC'D. BY REGISTRAR OCT 26 1982	25b. REGISTRAR'S SIGNATURE John J. Connel

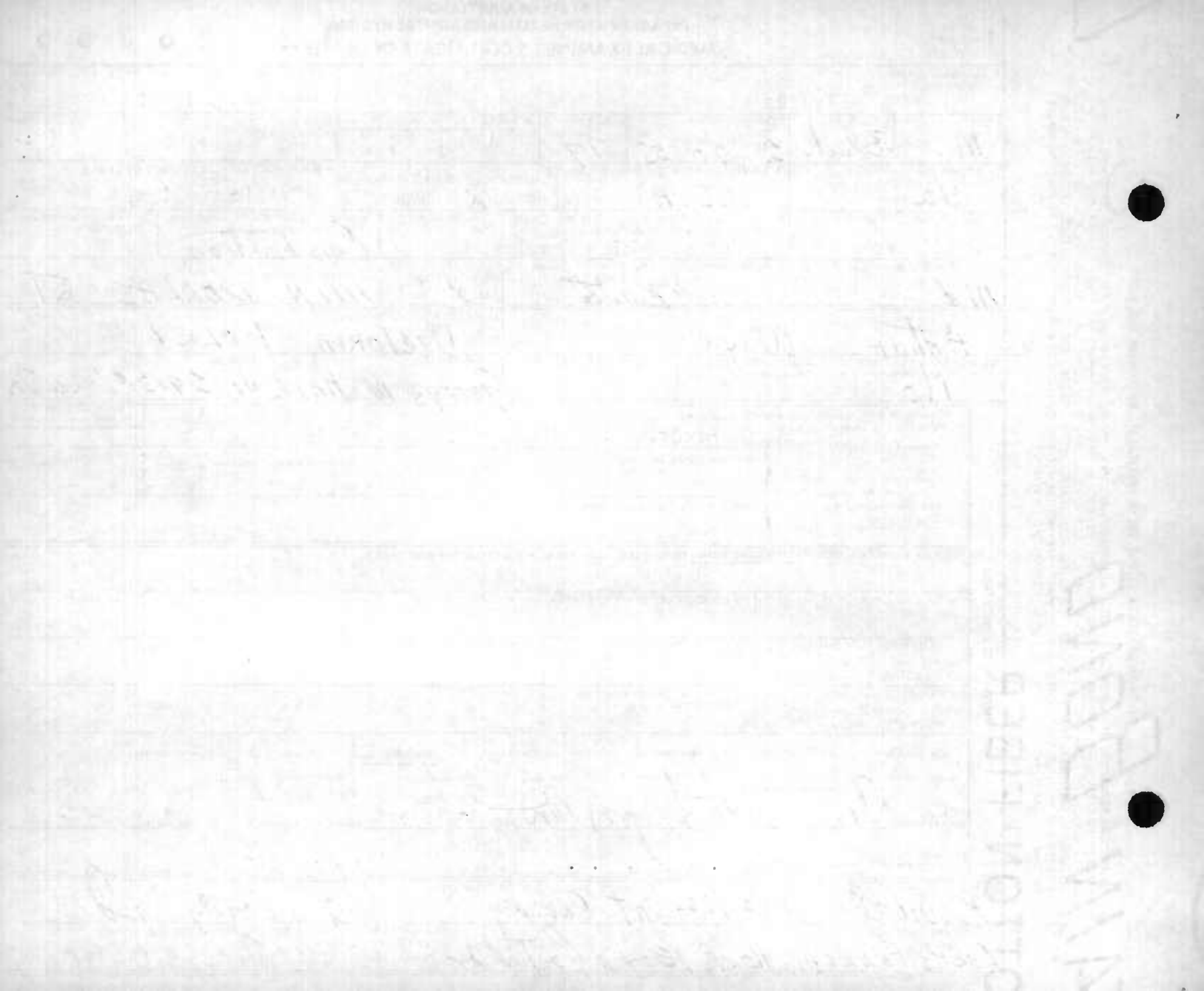
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

3
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26386	
1. FOR STATE REGISTRAR										26386	
1. DECEASED NAME (TYPE OR PRINT) Ulysses Wise										2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH 10 DAY 23 YEAR 1982	
3. SEX M. 4. RACE Black 5. DATE OF BIRTH MONTH 2 DAY 20 YEAR 05 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. 7. IF UNDER 1 YR. MONTHS 0 DAYS 0 8. IF UNDER 24 HRS. HOURS 0 MIN 0										2b. DATE OF DEATH <input type="checkbox"/> MONTH 10 DAY 23 YEAR 1982 2d. HOUR 12:20 P.M.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. 7b. CITIZEN OF WHAT COUNTRY? U.S.A. 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>										9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.	
10. CITY OR TOWN OF DEATH Baltimore 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Construction 12b. KIND OF BUSINESS OR INDUSTRY											
13a. STATE MD 13b. COUNTY BALTIMORE 13c. CITY OR TOWN BALTIMORE 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET ADDRESS 1111 N. DALLAS ST											
14. FATHER'S NAME FIRST Arthur MIDDLE Wise LAST Wise 15. MOTHER'S MAIDEN NAME FIRST Victoria MIDDLE Foley LAST Foley											
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No 16b. SOCIAL SECURITY NO. 000-00-0000 17. INFORMANT ADDRESS George M. Hall Jr. 2913 Chelton Dr											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic Cardiovascular Disease 4292 (b) _____ (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a).											
19a. DATE OF OPERATION _____ 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? _____ 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH _____ 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) _____											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) _____ 21f. LOCATION STREET _____ CITY OR TOWN _____ COUNTY _____ STATE _____											
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE Dennis F. Smyth M.D. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 10-24-82											
EXAMINER'S NAME (TYPE OR PRINT) Dennis F. Smyth, M.D. ADDRESS 111 Penn Street											
23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) Burial 23b. DATE 10/27/82 23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary 23d. LOCATION CITY OR TOWN Baltimore COUNTY MD STATE MD											
24. FUNERAL DIRECTOR NAME Locks Funeral Home ADDRESS 1304 N. Central Ave 25a. DATE REC'D. BY REGISTRAR OCT 27 1982 25b. REGISTRAR'S SIGNATURE John J. Carver											



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 8 7

1. FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Virginia Wise			2a. DATE OF DEATH MONTH DAY YEAR Oct 5 1982		2b. HOUR 8:10 PM
3. SEX Female	4. RACE Negro	5. DATE OF BIRTH MONTH DAY YEAR 2 29 25		6. AGE (IN YEARS LAST BIRTHDAY) 57 YRS.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N. Carolina	7b. CITIZEN OF WHAT COUNTRY? USA	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH City, Balto. MD	
10. CITY OR TOWN OF DEATH Balto.	11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) South Balto. Gen Hosp.		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unknown		12b. KIND OF BUSINESS OR INDUSTRY —
13a. STATE MD.	13b. COUNTY A. Arundel	13c. CITY OR TOWN Glen Burnie	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET ADDRESS 7667 Spencer St	
14. FATHER'S NAME FIRST MIDDLE LAST David		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lila Prichett		16. ADDRESS 7861 Willing Ct.	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No		16b. SOCIAL SECURITY NO. 217-20-6660		17. INFORMANT SERETHA GRISWOLD	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1: DEATH WAS CAUSED BY 4409 IMMEDIATE CAUSE (a) Cardiac arrest		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
DUE TO, OR AS A CONSEQUENCE OF (b) congestive heart failure		
DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis		

PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

19a. DATE OF OPERATION 10/5/82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Rectal bleeding	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19	21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2)	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)	21f. LOCATION STREET CITY OR TOWN COUNTY STATE	
22a. I certify that (I) (this hospital) attended the deceased from 9/22/82 , 19 82 , to 10/5/82 , 19 82 , that (I) (we) lost saw the deceased live on Oct 5 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If we (did) (did not) view the body after death.)				
22b. SIGNATURE Alan Dennis		DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/5/82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) Alan. Dennis		22e. ADDRESS 3001. S. Hanover St. Balto. MD.		

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL	23b. DATE 10/9/82	23c. NAME OF CEMETERY OR CREMATORY Mt. Calvary	23d. LOCATION CITY OR TOWN COUNTY STATE Brooklyn Md.
24. FUNERAL DIRECTOR NAME ADDRESS LEEON HARRIS F/S 4520 Penhury Rd.		25a. DATE REC'D. BY REGISTRAR OCT 7 1982	
		25b. REGISTRAR'S SIGNATURE Joan J. Casriel	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be called to certify the cause of death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

(IMPORTANT: If item 21 is marked or item 1B shows any injury, or other traumatic agent, the medical examiner must be notified and a post-mortem examination required.)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

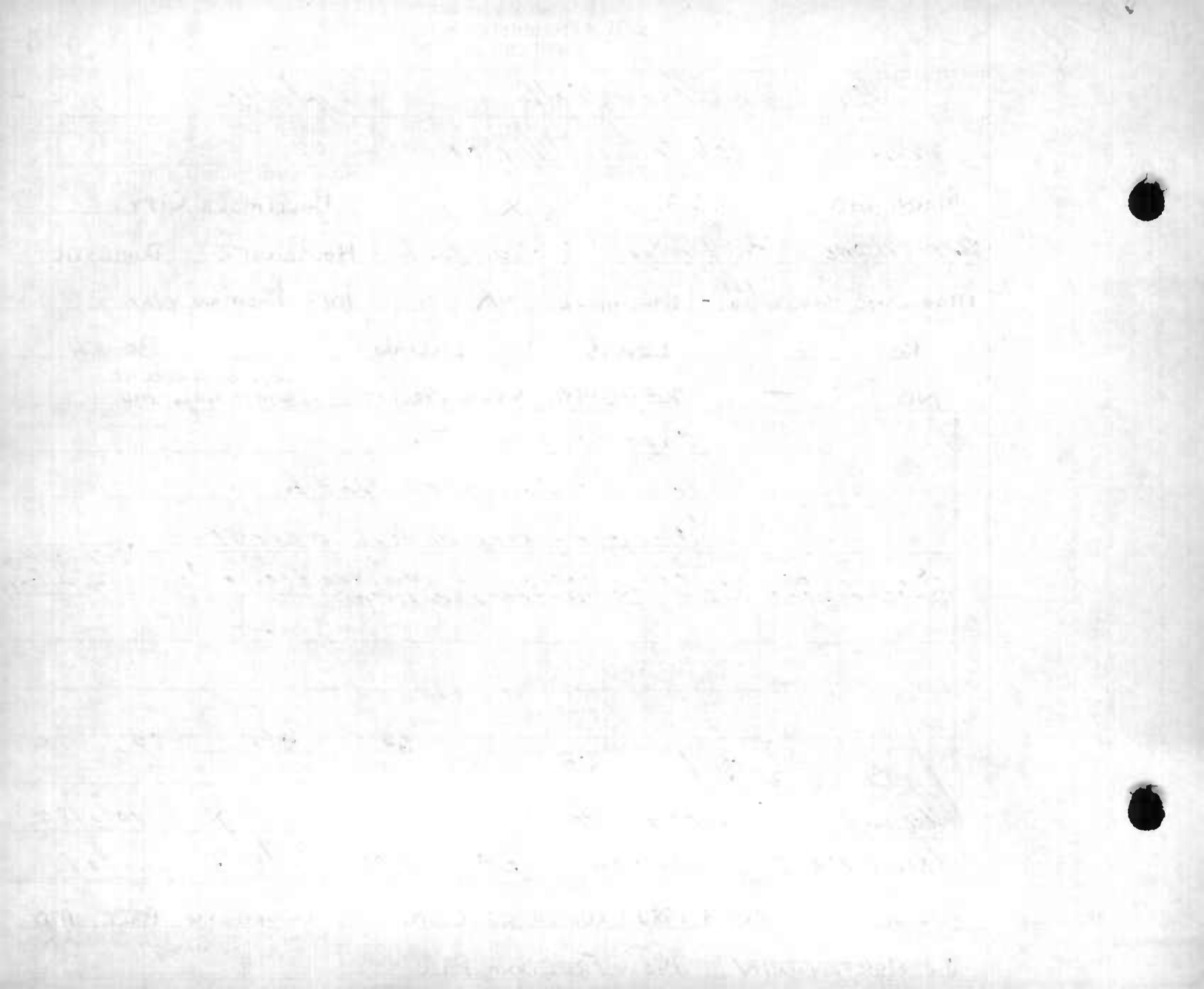
REG. NO.

8 2 2 6 3 8 8

1. FOR
STATE
REGISTRAR

1. DECEASED NAME (TYPE OR PRINT) <i>Lillian Mae Wolfe</i>			2a. DATE OF DEATH MONTH DAY YEAR <i>10/1/82</i>			2b. HOUR <i>11:20 A.M.</i>				
3. SEX <i>Female</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>11/1/04</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>77</i> YRS		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.		
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>MARYLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY</i> MD.				
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Baltimore City Hospitals</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Domestic</i>		
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>MARYLAND</i>			13b. COUNTY <i>INDEPENDANT</i>		13c. CITY OR TOWN <i>BALTIMORE</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>1013 Rodman Way</i>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>ROY</i>			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>LILLIAN BROWN</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>NO</i>			16b. SOCIAL SECURITY NO. <i>205-16-4897</i>		17. INFORMANT <i>VIRGINIA PRUETT</i>		ADDRESS <i>1029 WISEBURG RD. WHITE HALL MD.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for 1a), 1b), and 1c) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cardiac arrest.</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF 1b) <i>ventricular fibrillation</i> DUE TO, OR AS A CONSEQUENCE OF 1c) <i>Cardio-Respiratory arrest.</i>								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1. <i>Small Bowel obstruction & perforation. Coronary artery disease. Post op. Diabetic ulcers.</i>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)				
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)			21f. LOCATION STREET CITY OR TOWN COUNTY STATE				
22a. I certify that (I) (this hospital) attended the deceased from <i>10/1/82</i> to <i>10/1/82</i> , that (I) (we) last saw the deceased <i>above</i> on <i>10/1/82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) did <i>not</i> see the body after death.										
22b. SIGNATURE <i>Myrna Estruch, MD</i>			DEGREE			ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <i>10/1/82</i>		
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>MYRNA T. ESTRUCH</i>			22e. ADDRESS <i>BALTIMORE City Hospital</i>							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>			23b. DATE <i>OCT. 4, 1982</i>		23c. NAME OF CEMETERY OR CREMATORY <i>WISEBURG CEM.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>WISEBURG BALT. MD</i>			
24. FUNERAL DIRECTOR NAME <i>J.J. HARTENSTEIN</i>			ADDRESS <i>NEW FREEDOM, PA</i>			25a. DATE REC'D. BY REGISTRAR <i>OCT 7 1982</i>				
25b. REGISTRAR'S SIGNATURE <i>John J. Hartenstein</i>										

MEDICAL CERTIFICATION



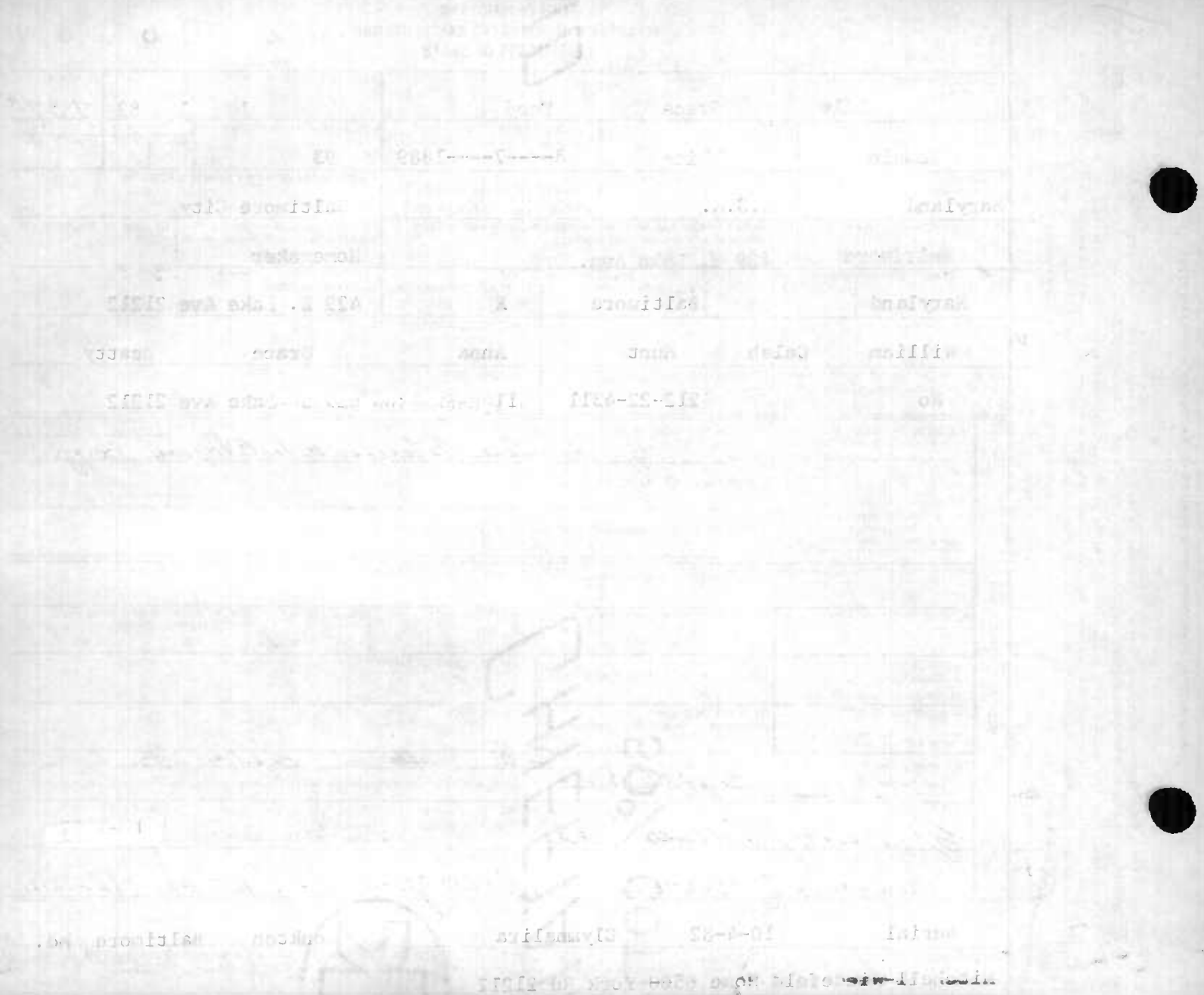
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH					8 2 2 6 3 8 9				
1- FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) Lily Grace Wood					2a. DATE OF DEATH MONTH DAY YEAR 10 1 82			2b. HOUR 7:37^{AM}	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 8----7----1889		6. AGE (IN YEARS LAST BIRTHDAY) 93 YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 429 E. Lake Ave.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 429 E. Lake Ave 21212	
14. FATHER'S NAME FIRST MIDDLE LAST William Caleb Hunt					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Anna Grace Beatty				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-22-4311		17. INFORMANT ADDRESS Allen H. Wood 429 E. Lake Ave 21212					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u><i>Myocardial Infarction</i></u> 4029 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u><i>30 yrs</i></u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: _____									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <u><i>July</i></u> , 19 <u><i>46</i></u> , to <u><i>Sept. 30</i></u> , 19 <u><i>82</i></u> , that (I) (we) last saw the deceased alive on <u><i>Sept. 29</i></u> , 19 <u><i>82</i></u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>Frederick J. Vollmer, M.D.</i>				DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10-1-82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FREDERICK J VOLLMER				22e. ADDRESS 6100 York RR BALTIMORE MD 21212					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10-4-82		23c. NAME OF CEMETERY OR CREMATORY Clymnalira		23d. LOCATION CITY OR TOWN COUNTY STATE Monkton Baltimore Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home 6500 York Rd 21212				25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE OCT 6 1982					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										
CERTIFICATE OF DEATH										
REG. NO. 8 2 2 6 3 9 0										
1. FOR STATE REGISTRAR					2a. DATE OF DEATH					
I. DECEASED NAME (TYPE OR PRINT)					MONTH DAY YEAR HOUR					
Mary A. Woodward					10 1 82 8:10 A.M.					
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (IN YEARS LAST BIRTHDAY)		7. IF UNDER 1 YEAR		
Female		White		MONTH DAY YEAR		88 YRS.		MONTHS DAYS HOURS MIN.		
8. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH				
Maryland		U.S.A.				Baltimore City MD.				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY		
Baltimore City		Hamilton Nursing Center				Housewife				
13a. STATE					13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?	
Maryland							Baltimore		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME					15. MOTHER'S MAIDEN NAME					
Joseph Popp					Barbara Hudeck					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)					16b. SOCIAL SECURITY NO.		17. INFORMANT ADDRESS			
No					215-09-8813		Arthur C. Woodward 3439 Woodstock Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										
PART I. DEATH WAS CAUSED BY:										
IMMEDIATE CAUSE (a) <i>Cardiac arrest</i>										
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:										
<i>Severe Anemia, Paget Disease of the Bone</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH?			
					YES <input type="checkbox"/> NO <input type="checkbox"/>		YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)						
		P.M. 19								
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that (I) (this hospital) attended the deceased from <i>June 19 82</i> to <i>Oct 1 19 82</i> , that (I) (we) last saw the deceased alive on <i>Sept 28 19 82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (If (we) (did) (did not) view the body after death.										
22b. SIGNATURE					DEGREE			22c. DATE SIGNED		
<i>Howard H. Bond</i>					M.D.			1 Oct 82		
22d. PHYSICIAN'S NAME (TYPE OR PRINT)					22e. ADDRESS					
Howard H. Bond, M.D.					9618 Belair Road Baltimore, Maryland					
23a. BURIAL, CREMATION, REMOVAL		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE				
Burial		Oct. 4, 1982		Parkwood		Baltimore Maryland				
24. FUNERAL DIRECTOR NAME ADDRESS						25a. DATE REC'D. BY REGISTRAR				
Leonard J. Ruck, Inc. Baltimore, Maryland						OCT 4 1982				

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

8 2 2 6 3 9 1

1. DECEASED NAME (TYPE OR PRINT) <i>William H. Wooters</i>				2a. DATE OF DEATH MONTH DAY YEAR <i>10-23-82</i>				2b. HOUR M	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>4-30-1909</i>		6. AGE (IN YEARS LAST BIRTHDAY) YEARS MONTHS DAYS <i>73</i>		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Balto. Md.</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>Baltimore City</i> MD.			
10. CITY OR TOWN OF DEATH <i>Baltimore</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Good Samaritan Hospital</i>				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Md. Natl. Guard</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Retired</i>	
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Md.</i>				13b. COUNTY <i>Balto.</i>		13c. CITY OR TOWN <i>Balto.</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <i>Daniel Wooters</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Rose Walters</i>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>Yes</i>		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WWII</i> <i>213-03-3582</i>		17. INFORMANT ADDRESS <i>Mrs. Marie B. Wooters - 3010 Glenmore Ave. 21214</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Myocardial Infarction</i> <i>4100</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Arteriosclerotic Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Congestive Heart Failure Diabetes Mellitus</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from <i>7/29</i> , 19 <i>81</i> , to <i>9/13</i> , 19 <i>82</i> , that (I) (we) lost saw the deceased alive on <i>9/13</i> , 19 <i>82</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>George E. LaRocco</i>				DEGREE <i>MD</i>		ATTENDING MEDICAL STAFF PHYSICIAN <input checked="" type="checkbox"/> DIRECTOR <input type="checkbox"/> PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <i>10/25/82</i>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>George E. LaRocco</i>				22e. ADDRESS <i>7600 Foster Drive Towson Md</i>					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		23b. DATE <i>10-27-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Maryland Veterans Cem. Crownsville Md.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE		23e. DATE REC'D. BY REGISTRAR	
24. FUNERAL DIRECTOR NAME ADDRESS <i>John C. Miller Inc-6415 Belair Rd.-21206</i>				23f. DATE REC'D. BY REGISTRAR <i>OCT 26 1982</i>		23g. REGISTRAR'S SIGNATURE <i>John J. Connel</i>			

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1. *Chlorophyll a* (Chl a) is the primary photosynthetic pigment in most plants and algae. It is a green pigment that absorbs light energy in the blue-violet and red-orange regions of the visible spectrum. Chl a is essential for the light-dependent reactions of photosynthesis, where it converts light energy into chemical energy in the form of ATP and NADPH.

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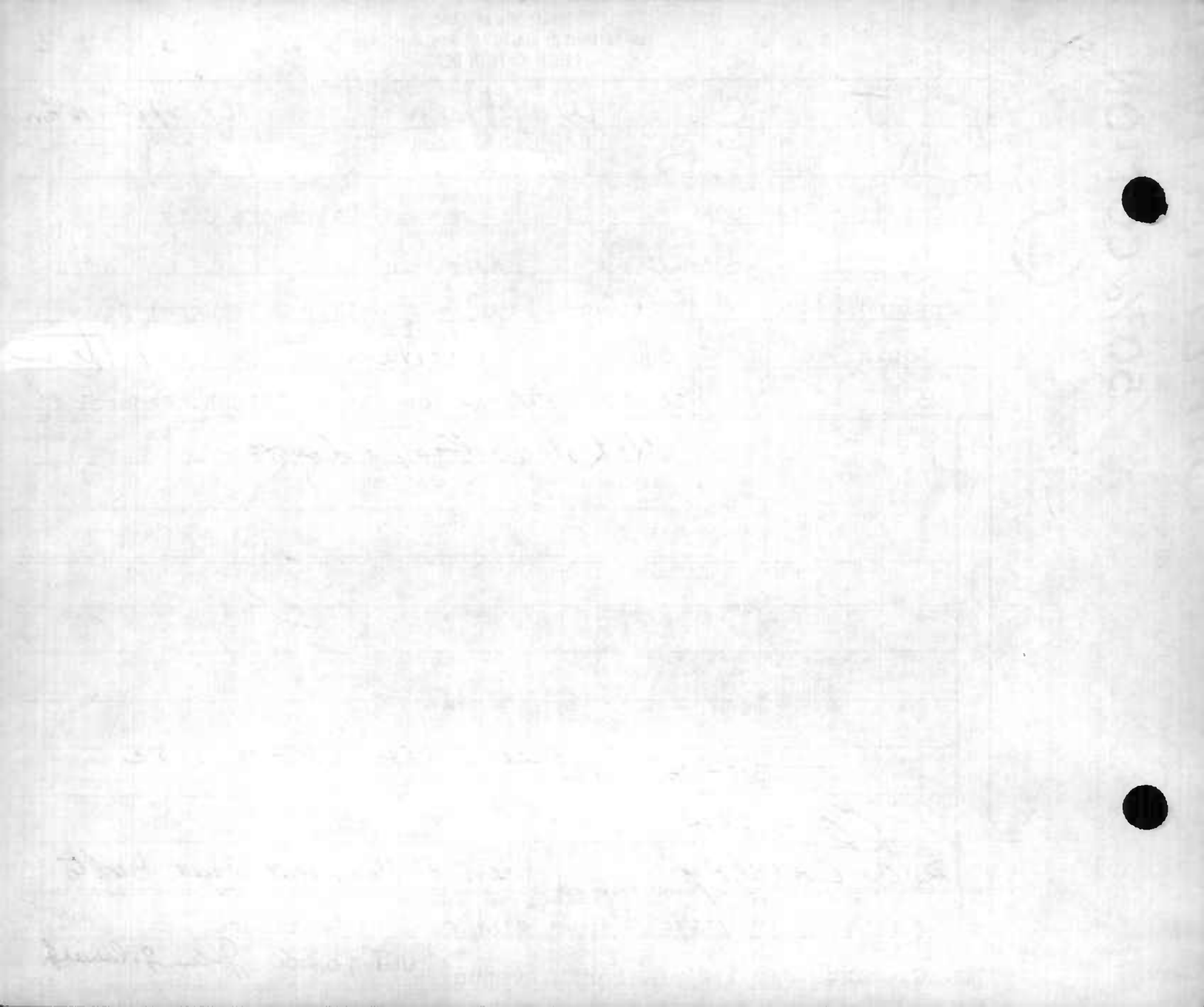
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

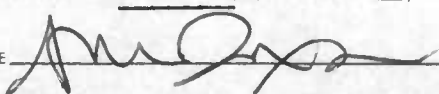
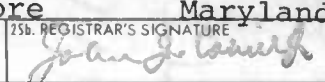
MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE					8 2 2 6 3 9 2				
FOR STATE REGISTRAR					REG. NO.				
1. DECEASED NAME (TYPE OR PRINT) J C Worthen					2a. DATE OF DEATH MONTH DAY YEAR 10/16/82 10 ⁴⁵ AM				
3 SEX M		4 RACE B		5. DATE OF BIRTH MONTH DAY YEAR 7 26 26		6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) S. Carolina		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.			
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Greater Penn Nursing Ctr				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 1719 E. Federal St.	
14. FATHER'S NAME FIRST MIDDLE LAST Louis Goods					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Baetrice Thomas				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. 249-20-0135		17. INFORMANT ADDRESS Bea-ricce Thomas 1719 E. Federal St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Gastric Cancer 1519 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 9-21 , 19 82 , to 10-16 , 19 82 , that (I) (we) last saw the deceased alive on 10-16 , 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE R. O. CROSBY				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED	
22a. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS 1235 E. Monument Street Balto					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/19/82		23c. NAME OF CEMETERY OR CREMATORY Mount Zion Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Md.			
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 E. North Avenue				25a. DATE REC'D. BY REGISTRAR OCT 18 1982		25b. REGISTRAR'S SIGNATURE John J. Carver			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH										REG. NO. 26393	
1. DECEASED NAME (TYPE OR PRINT) FRANK W. WOZNIAK						2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTIMATED <input type="checkbox"/> 10 9 19 82		2b. HOUR 9:30			
3. SEX Male	4. RACE White	5. DATE OF BIRTH MONTH 9 DAY 27 YEAR 14 68 YRS.	6. AGE (IN YEARS LAST BIRTHDAY)	IF UNDER 1 YR. MONTHS xx DAYS	IF UNDER 24 HRS. HOURS xx MIN.	2c. DATE PRONOUNCED DEAD 10 9 19 82		2d. HOUR 9:30			
7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.					
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 306 Lehigh Street			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Shipping Clerk		12b. KIND OF BUSINESS Supermarket				
13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 306 Lehigh 21224			
14. FATHER'S NAME FIRST Andrew MIDDLE Wozniak LAST Wozniak				15. MOTHER'S MAIDEN NAME FIRST Ida MIDDLE Ida LAST Ida		ADDRESS 306 Lehigh St. Balto., MD. 21224					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		(IF YES, GIVE WAR OR DATES)		16b. SOCIAL SECURITY NO. 212-34-9262		17. INFORMANT Alvina Hartman		ADDRESS 306 Lehigh St. Balto., MD. 21224			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE						
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE 			M.D. Assistant			MEDICAL EXAMINER		DATE SIGNED 10-10-82			
EXAMINER'S NAME (TYPE OR PRINT) Ann M. Dixon, M.D.			ADDRESS 111 Penn St., Balto., Md. 21201								
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/13/1982		23c. NAME OF CEMETERY OR CREMATORY Holy Rosary			23d. LOCATION CITY OR TOWN Baltimore COUNTY Maryland STATE Maryland				
24. FUNERAL DIRECTOR NAME Duda-Ruck, Inc. ADDRESS 7922 Wise Avenue Dundalk, MD. 21222				25a. DATE REC'D. BY REGISTRAR OCT 13 1982		25b. REGISTRAR'S SIGNATURE 					

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1- FOR
STATE
REGISTRARDEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			3. SEX			4. RACE			5. DATE OF BIRTH			6. AGE (IN YEARS)			7. DATE OF DEATH			8. TIME OF DEATH		
FIRST MIDDLE LAST Damita Victoria Mackey Wright			MONTH DAY YEAR 10 26 1982			2b. HOUR 4:02P			2c. DATE PRONOUNCED DEAD			MONTH DAY YEAR 10 26 1982			2d. HOUR 4:02P								
9. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland			10. CITY OR TOWN OF DEATH Baltimore			11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital			12. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			13. KIND OF BUSINESS OR INDUSTRY											
14. FATHER'S NAME FIRST MIDDLE LAST Alfonzo Mackey			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Catherine Fisher			16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No			16b. SOCIAL SECURITY NO. N/A			17. INFORMANT Catherine Fisher			18. ADDRESS 2036 E. Hoffman St.								
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Sudden Infant Death Syndrome 7980 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____			APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH																				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).																							
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																	
21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19			21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)																	
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)			21f. LOCATION (STREET) CITY OR TOWN COUNTY STATE																	
22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion																				
ACTUAL SIGNATURE Thomas D. Smith, M.D.			TITLE (SPECIFY) Deputy Chief			DATE SIGNED 10/27/82																	
EXAMINER'S NAME (TYPE OR PRINT)			ADDRESS																				
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL			23b. DATE 10/30/82			23c. NAME OF CEMETERY OR CREMATORY Cedar Hill Cem			23d. LOCATION (CITY OR TOWN) COUNTY STATE Glenburnie Md.														
24. FUNERAL DIRECTOR NAME Wm. C. March F/H Inc.			ADDRESS 1101 E. North Avenue			25a. DATE READ BY REGISTRAR OCT 29 1982			25b. REGISTRAR'S SIGNATURE John J. Carney														

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH VITAL RECORDS. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



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ROBERT MORTON

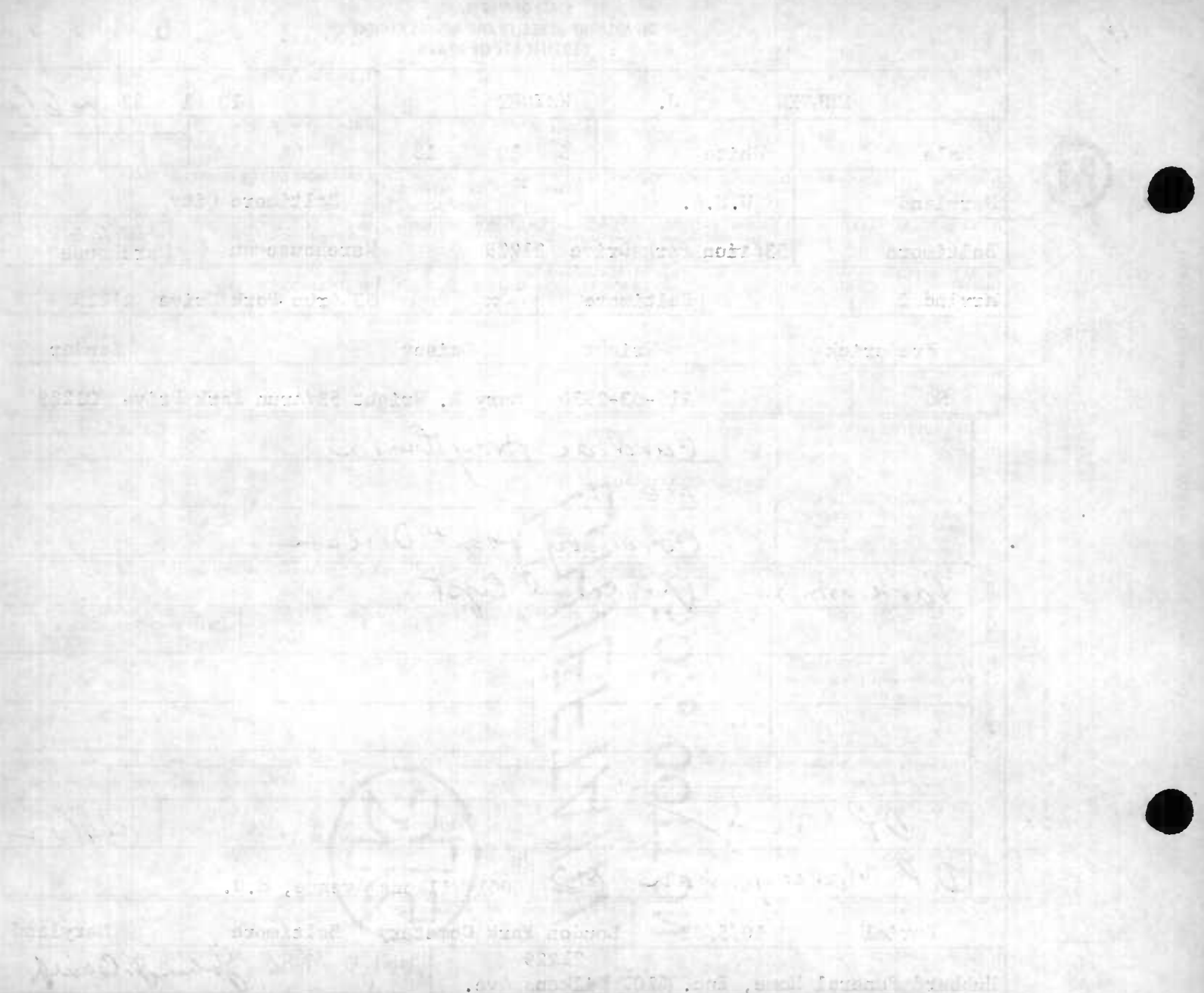
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE				8 2 2 6 3 9 5			
1. FOR STATE REGISTRAR				CERTIFICATE OF DEATH			
1. DECEASED NAME (TYPE OR PRINT)				2a. DATE OF DEATH			
FIRST MIDDLE LAST MELVIN J. WRIGHT				MONTH DAY YEAR 10 1 82			
3. SEX Male				2b. HOUR ~ 6 PM			
4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR 5 10 18		6. AGE (IN YEARS LAST BIRTHDAY) 64 YRS.		7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 53 Arion Park Drive 21229		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Warehouseman		12b. KIND OF BUSINESS OR INDUSTRY Warehouse	
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)				13a. STOPPET ADDRESS			
13a. STATE Maryland		13b. COUNTY		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Frederick Wright				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Daisey Sanders			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-03-2930		17. INFORMANT ADDRESS Mary R. Wright 53 Arion Park Drive 21229			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: 4140 IMMEDIATE CAUSE (a) Cardiac Arrhythmia DUE TO, OR AS A CONSEQUENCE OF (b) Aseptic DUE TO, OR AS A CONSEQUENCE OF (c) Coronary Heart Disease. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: Parkinsonism, (RP) Renal Cyst.							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE D. P. Malayaman MD				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/4/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. P. Malayaman MD				22e. ADDRESS 4001 Wilkens Avenue			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/5/82		23c. NAME OF CEMETERY OR CREMATORY Loudon Park Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS Hubbard Funeral Home, Inc. 4107 Wilkens Ave. 21229				25. DATE RECEIVED BY REGISTRAR (SEE REGISTRAR'S SIGNATURE) 10/11/82			



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (5))
20M 4/82

1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

1. DECEASED NAME (TYPE OR PRINT)			2a. DATE KNOWN OF DEATH			2b. DATE OF DEATH			2c. DATE OF DEATH		
FIRST MIDDLE LAST Mary Wujek			MONTH DAY YEAR 10-24-82			MONTH DAY YEAR 10-24-82			MONTH DAY YEAR 10-24-82		
3. SEX Female			4. RACE Cauc			5. DATE OF BIRTH Sept 8 1901			6. AGE (IN YEARS) 73 YRS.		
7. PLACE OF BIRTH (STATE OR COUNTRY) Ohio			8. CITIZENSHIP U.S.A.			9. MARRIED WIDOWED			10. DATE OF DEATH 10-24-82		
11. CITY OR TOWN OF DEATH Baltimore			12. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Johns Hopkins Hospital			13. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Homemaker			14. KIND OF BUSINESS OR INDUSTRY Home		
15. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENTIAL ADDRESS) Md			16. COUNTY Baltimore			17. INSIDE CITY LIMITS? YES X NO			18. STREET ADDRESS 601 S. Race St.		
19. FATHER'S NAME John			20. MOTHER'S MAIDEN NAME Antonina			21. SOCIAL SECURITY NO. 214-16-9447			22. INFORMANT Mary Wujek		
23. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, GIVE WAR OR DATES) No			24. SOCIAL SECURITY NO. 214-16-9447			25. ADDRESS 1843 Lockwood Rd			26. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Arteriosclerotic cardiovascular disease 4292 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a).											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES NO X			
21a. EXTERNAL CAUSE WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE AT WORK OR NOT WHILE AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> .											
ACTUAL SIGNATURE Margarita A. Korell				TITLE (SPECIFY) M.D. Assistant				DATE SIGNED 10-25-82			
EXAMINER'S NAME (TYPE OR PRINT) Margarita A. Korell, M.D.				ADDRESS 111 Penn Street							
23a. BURIAL, CREMATION, REMOVAL				23b. DATE 10-28-82				23c. NAME OF CEMETERY OR CREMATORY St. Stanislaus			
23d. CITY OR TOWN Baltimore				23e. COUNTY Md				23f. STATE			
24. FUNERAL DIRECTOR Raymond Kozminski				ADDRESS 2550 North				DATE REC'D. BY REGISTRAR OCT 26 1982			
25. REGISTRAR'S NAME John J. Smith											



Bohner

189
189
189

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

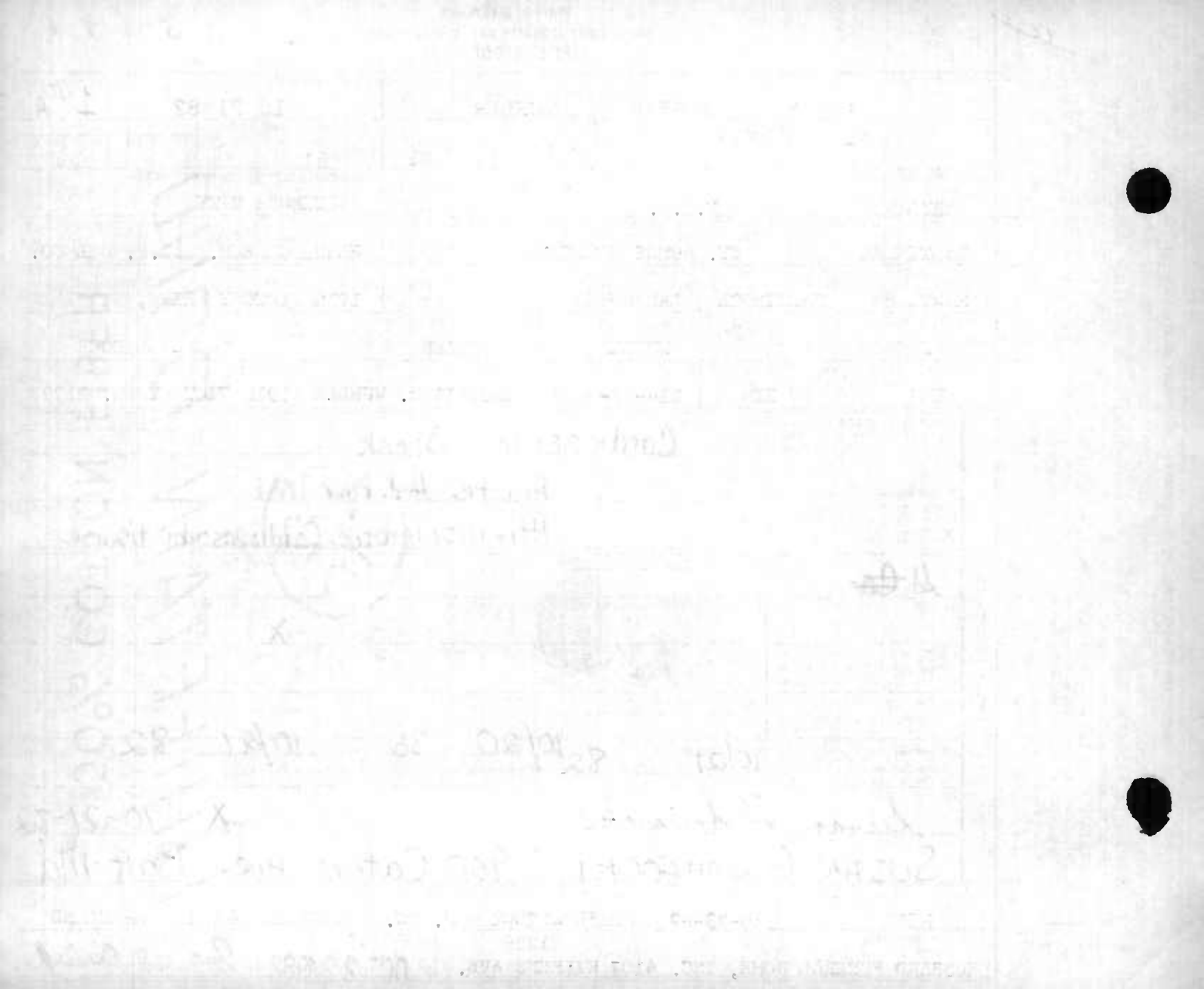
1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

8 2 2 6 3 9 7

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST WILLIAM JOSEPH WUNDER			2a. DATE OF DEATH MONTH DAY YEAR 10 21 82		2b. HOUR 1:40 A.M.	
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 09 14 21		6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS.
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) ST. AGNES HOSPITAL			12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HEATING MECH.	
12b. KIND OF BUSINESS OR INDUSTRY B.P. OIL CO.						
13a. STATE MARYLAND			13b. COUNTY BALTIMORE		13c. CITY OR TOWN LANDSOWNE	
14. FATHER'S NAME FIRST MIDDLE LAST JOSEPH WUNDER			15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST HELEN ESSLINGER			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES			16b. SOCIAL SECURITY NO. 214-12-0075		17. INFORMANT ADDRESS VIRGINIA M. WUNDER 1918 VICTORY DR. 21227	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Cardiogenic Shock DUE TO, OR AS A CONSEQUENCE OF (b) Acute Anterior MI DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerotic Cardiovascular disease APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH						
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) A. E.						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>						
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 10/20 82 P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)		
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE 900 Caton Ave Balt Md		
22a. I certify that (I) (this hospital) attended the deceased from 10/21 82 to 10/21 82 that (I) (we) last saw the deceased alive on 10/21 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b. SIGNATURE Susan G Smigocki				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10-21-82
22d. PHYSICIAN'S NAME (TYPE OR PRINT) SUSAN G SMIGOCKI				22e. ADDRESS 900 Caton Ave Balt Md		
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10-23-82		23c. NAME OF CEMETERY OR CREMATORY MEADOWRIDGE MEM. PK.		23d. LOCATION CITY OR TOWN COUNTY STATE ELKRIDGE HOWARD MARYLAND
24. FUNERAL DIRECTOR NAME ADDRESS HUBBARD FUNERAL HOME, INC. 4107 WILKENS AVE. 21229				25a. DATE REC'D. BY REGISTRAR OCT 22 1982		25b. REGISTRAR'S SIGNATURE John J. Connel



STATE OF MARYLAND
 DEPARTMENT OF HEALTH AND MENTAL HYGIENE
 CERTIFICATE OF DEATH

8 2 2 6 3 9 8

1 - FOR
STATE
REGISTRAR

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) Georgeanna ^{FIRST} Yarbrough ^{MIDDLE} ^{LAST} GEORGIANNA (YARBOROUGH)			2a. DATE OF DEATH MONTH DAY YEAR October 14 1982		2b. HOUR 1 ¹⁵ P.M.		
3. SEX female		4. RACE black		5. DATE OF BIRTH MONTH DAY YEAR 3 4 1908		6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. MONTHS DAYS	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) N.C.		7b. CITIZEN OF WHAT COUNTRY? U S A		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE CITY MD.	
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Md		13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST Maxwell Johnson		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)		16b. SOCIAL SECURITY NO. N/A	
17. INFORMANT Rayford Yarbrough		ADDRESS 11 W. 20th Street Apt 3 J		17. INFORMANT Rayford Yarbrough		ADDRESS 11 W. 20th St Apt 3 J	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).
PART I. DEATH WAS CAUSED BY:

5850

IMMEDIATE CAUSE (a) Chronic Renal Failure

DUE TO, OR AS A CONSEQUENCE OF

Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.(b) _____
DUE TO, OR AS A CONSEQUENCE OF

(c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1:

CHF, S/p CVA & seizures, Angine

19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (we) last saw the deceased alive on October 14, 1982, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.							
22b. SIGNATURE Wendy Kloesz		DEGREE M.D.		22c. DATE SIGNED 10/14/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) WENDY KLOESZ		22e. ADDRESS UNION MEMORIAL HOSPITAL					

23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 10/19/82		23c. NAME OF CEMETERY OR CREMATORY Md Nat Memorial Park		23d. LOCATION CITY OR TOWN COUNTY STATE Laurel Md	
24. FUNERAL DIRECTOR William C. March F/H 1101 E. North Avenue				25a. DATE REC'D. BY REGISTRAR OCT 18 1982		25b. REGISTRAR'S SIGNATURE John J. Conner	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 6 3 9 9			
1. FOR STATE REGISTRAR				REG. NO.			
1. DECEASED NAME <u>John F. Yeager Jr.</u> (TYPE OR PRINT) <u>JOHN YEAGER</u>				2a. DATE OF DEATH MONTH DAY YEAR <u>10-25-82</u>		2b. HOUR <u>6:50 PM</u>	
3. SEX <u>Male</u>		4. RACE <u>Caucasian</u>		5. DATE OF BIRTH MONTH DAY YEAR <u>11-24-1904</u>		6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS <u>77</u> YRS <u>9</u>	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Md.</u>		7b. CITIZEN OF WHAT COUNTRY? <u>USA</u>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <u>Baltimore City</u> MD.	
10. CITY OR TOWN OF DEATH <u>Baltimore</u>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Mercy Hospital</u>		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Postal Clerk</u>		12b. KIND OF BUSINESS OR INDUSTRY <u>Office</u>	
13a. STATE <u>Md.</u>		13b. COUNTY <u>Baltimore</u>		13c. CITY OR TOWN <u>Baltimore</u>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME FIRST MIDDLE LAST <u>John F. Yeager Sr.</u>		15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>Christina Domeier</u>		13e. STREET ADDRESS <u>524 N. Charles St. Apt 1113</u>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>Yes</u>		16b. SOCIAL SECURITY NO. <u>WWII 212-09-5813</u>		17. INFORMANT ADDRESS <u>Towson, Md. 21204</u> <u>Flora Helm 40 Acorn Circle</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: <u>1629</u> IMMEDIATE CAUSE (a) <u>acute respiratory failure</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>probable aspiration</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>metastatic CA lung</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>~ 48 hrs.</u>							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>severe COPD; CHF</u>							
19a. DATE OF OPERATION <u>10/24/82</u>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <u>Swan Ganz catheter</u>		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <u>19</u>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (this hospital) attended the deceased from <u>10/15</u> , 19 <u>82</u> , to <u>10/25</u> , 19 <u>82</u> , that (I) (we) last saw the deceased alive on <u>10/25</u> , 19 <u>82</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <u>Sargant J. Keeler MD</u>				DEGREE <u>ATTENDING PHYSICIAN</u> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED <u>10/25/82</u>	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>MARGARET L. KEELER, M.D.</u>				22e. ADDRESS <u>MERCY HOSPITAL, BALTIMORE 21203</u>			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		23b. DATE <u>10-29-82</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Dulaney Valley Cem.</u>		23d. LOCATION CITY OR TOWN COUNTY STATE <u>Balto., Md.</u>	
24. FUNERAL DIRECTOR NAME <u>Schimunek Funeral Home, Inc.</u>		ADDRESS <u>3331 Brehms Lane, Balto., Md.</u>		25a. DATE REC'D. BY REGISTRAR <u>OCT 23 1982</u>		25b. REGISTRAR'S SIGNATURE <u>John J. Grier</u>	

RECEIVED
FEB 10 1964

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner will be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 4 0 0 REG. NO.					
1. FOR STATE REGISTRAR										2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
1. DECEASED NAME (TYPE OR PRINT) VIRGINIA V. YEAGER										10/4/82				540 PM	
3. SEX FEMALE			4. RACE WHITE			5. DATE OF BIRTH MONTH DAY YEAR 7/13/26			6. AGE (IN YEARS LAST BIRTHDAY) 56 YRS.			7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD			7b. CITIZEN OF WHAT COUNTRY? USA			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE MD.						
10. CITY OR TOWN OF DEATH BALTIMORE			11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WYMAN PARK HEALTH SYS						12a. USUAL OCCUPATION (TYPE OR WORK FOR MOST OF WORKING LIFE) HW			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD			13b. COUNTY			13c. CITY OR TOWN Baltimore			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			13e. STREET ADDRESS 2713 MILES AV. 21211			
14. FATHER'S NAME FIRST MIDDLE LAST SULLIVAN, Harry J.						15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Emma ZEP									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No						16b. SOCIAL SECURITY NO. 219191316			17. INFORMANT ADDRESS Carolyn J. Walters, 653 Kingston Rd 21220						
18. CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RESPIRATORY FAILURE 1749														APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last														DUE TO, OR AS A CONSEQUENCE OF (b) BREAST DIFFUSE LUNG METASTASIS OF CANCER 9 months	
DUE TO, OR AS A CONSEQUENCE OF (c) CANCER OF BREAST 9 months															
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: 0															
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19				21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)				21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.															
22b. SIGNATURE F. Delgado MD										DEGREE		22c. DATE SIGNED 10/4/82			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) FERNANDO DELGADO										22e. ADDRESS WYMAN PARK HEALTH SYS					
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial				23b. DATE 8 Oct 1982		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Cemetery				23d. LOCATION CITY OR TOWN COUNTY STATE Woodlawn, Balto Co Maryland					
24. FUNERAL DIRECTOR NAME BURGEE Funeral Home, Baltimore, Maryland ADDRESS										25a. DATE REC'D. BY REGISTRAR OCT. 6. 1982		25b. REGISTRAR'S SIGNATURE John J. Conner			



United States Department of State
 Bureau of Intelligence and Research
 Office of the Director
 Washington, D.C. 20520
 Date: 10/10/65
 To: Mr. Tolson
 From: Mr. [illegible]
 Subject: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed, it should be filed in the funeral director's office. Pages 1 and 2 should be filed with the funeral director, page 3 with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE										8 2 2 6 4 0 1			
1. FOR STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JAMES F. YOUNG						2a. DATE OF DEATH MONTH DAY YEAR 10-13-82				2b. HOUR 6:42pm			
3. SEX male		4. RACE Black		5. DATE OF BIRTH MONTH DAY YEAR 12 25 41		6. AGE (IN YEARS LAST BIRTHDAY) 40 YRS.		IF UNDER 1 YEAR MONTHS DAYS 40		IF UNDER 24 HRS. HOURS MIN. 40			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City, MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Church Home and Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)			12b. KIND OF BUSINESS OR INDUSTRY				
USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION)						13d. INSIDE CITY LIMITS? YES xx NO <input type="checkbox"/>			13e. STREET ADDRESS 511 S. Bond St.				
13a. STATE Md.		13b. COUNTY		13c. CITY OR TOWN Balto.									
14. FATHER'S NAME FIRST MIDDLE LAST Carlos Young				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Audrey Jones									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-40-0036		17. INFORMANT ADDRESS Dorothea Russell 4519 Marble Hall Rd									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) RENAL FAILURE 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) NEPHROSCLEROSIS (c) ARTERIOSCLEROTIC CARDIO VASCULAR DISEASE WITH HYPERTENSION										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I. (1.) SEVERE METABOLIC ACIDOSIS (2.) COMA SECONDARY TO SEVERE BRAIN DAMAGE. (3.) RESPIRATORY FAILURE SECONDARY TO COMA.													
19a. DATE OF OPERATION 09-24-82		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED TRACHEOSTOMY				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2)									
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 09-19- 19 82 to 10-13- 19 82 , that (I) <input checked="" type="checkbox"/> saw the deceased alive on 10-13- 19 82 , and that in (my) <input checked="" type="checkbox"/> opinion death occurred on the date and hour and from the causes stated above, (I) <input checked="" type="checkbox"/> did not view the body after death.													
22b. SIGNATURE OF PHYSICIAN A. F. NOUR						DEGREE MD ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/13/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. A. F. NOUR MD.						22e. ADDRESS CHURCH HOSPITAL CORPORATION 100 N. BROADWAY BALTIMORE, MARYLAND 21231							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL		23b. DATE 10/20/82		23c. NAME OF CEMETERY OR CREMATORY Mount Calvary Cem		23d. LOCATION CITY OR TOWN COUNTY STATE Anne Arundel Co Md.							
24. FUNERAL DIRECTOR NAME Wm. C. March F/H 1101 e.		ADDRESS North Avenue		DATE REC'D BY REGISTRAR OCT 18 1982		REGISTRAR'S SIGNATURE John J. Connel							

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 4 0 2	
1. FOR STATE REGISTRAR				REG. NO.							
1. DECEASED NAME (TYPE OR PRINT)				FIRST MIDDLE LAST		2a. DATE OF DEATH MONTH DAY YEAR				2b. HOUR	
Jesse E Young						10/20/82				4:20PM	
3. SEX		4. RACE		5. DATE OF BIRTH MONTH DAY YEAR		6. AGE (IN YEARS LAST BIRTHDAY)		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
Male		Black		1 28 13		69 YRS					
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS)						12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE)		12b. KIND OF BUSINESS OR INDUSTRY	
Baltimore		John Hopkins Hospital									
13a. STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS		21202	
Md.				Balto.				1317 Ensor St.			
14. FATHER'S NAME FIRST MIDDLE LAST				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST							
Unkn				Unkn							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN)				16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS					
No						Ophelia Anderson 1317 Ensor St.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypotension, respiratory failure DUE TO, OR AS A CONSEQUENCE OF (b) adenocarcinoma, unknown DUE TO, OR AS A CONSEQUENCE OF (c) primary Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost 1991 APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 12 hours unknown											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): bilateral pleural effusion											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)					
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK				21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE					
22a. I certify that (I) (this hospital) attended the deceased from 82/10/16, 19 82, to 10/20, 19 82, that (I) (we) last saw the deceased alive on 10/20, 19 82, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE S. E. NOLAN				DEGREE MD				ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED 10/20/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) S. E. NOLAN				22e. ADDRESS John Hopkins Hospital, Balto, Md							
23a. BURIAL, CREMATION, REMOVAL (SPECIFY)				23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION CITY OR TOWN COUNTY STATE			
Burial				10/25/82		King Mem. Park		Baltimore Co., Md.			
24. FUNERAL DIRECTOR NAME ADDRESS Wm C Ma-ch F/H, Inc. 1101 E. North Ave.						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John J. Connel			
						OCT 25 1982					

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YOUNG, 68, 10/20/82

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1. The first part of the report is a general statement of the purpose and scope of the study. It is followed by a brief review of the literature on the subject.

2. The second part of the report is a description of the methods used in the study. This includes a discussion of the subjects, the instruments used, and the procedures followed.

3. The third part of the report is a presentation of the results of the study. This is done in the form of a series of tables and graphs.

4. The fourth part of the report is a discussion of the results. This includes a comparison of the results with those of other studies and a discussion of the implications of the findings.

5. The fifth part of the report is a conclusion. This summarizes the main findings of the study and offers some suggestions for further research.

6. The sixth part of the report is a list of references. This includes a list of all the books, articles, and other sources used in the study.

7. The seventh part of the report is an appendix. This contains any additional material that is relevant to the study but that does not fit into the main body of the report.

8. The eighth part of the report is a bibliography. This is a list of all the books, articles, and other sources used in the study.

9. The ninth part of the report is a list of figures. This includes a list of all the tables and graphs used in the study.

10. The tenth part of the report is a list of tables. This includes a list of all the tables used in the study.



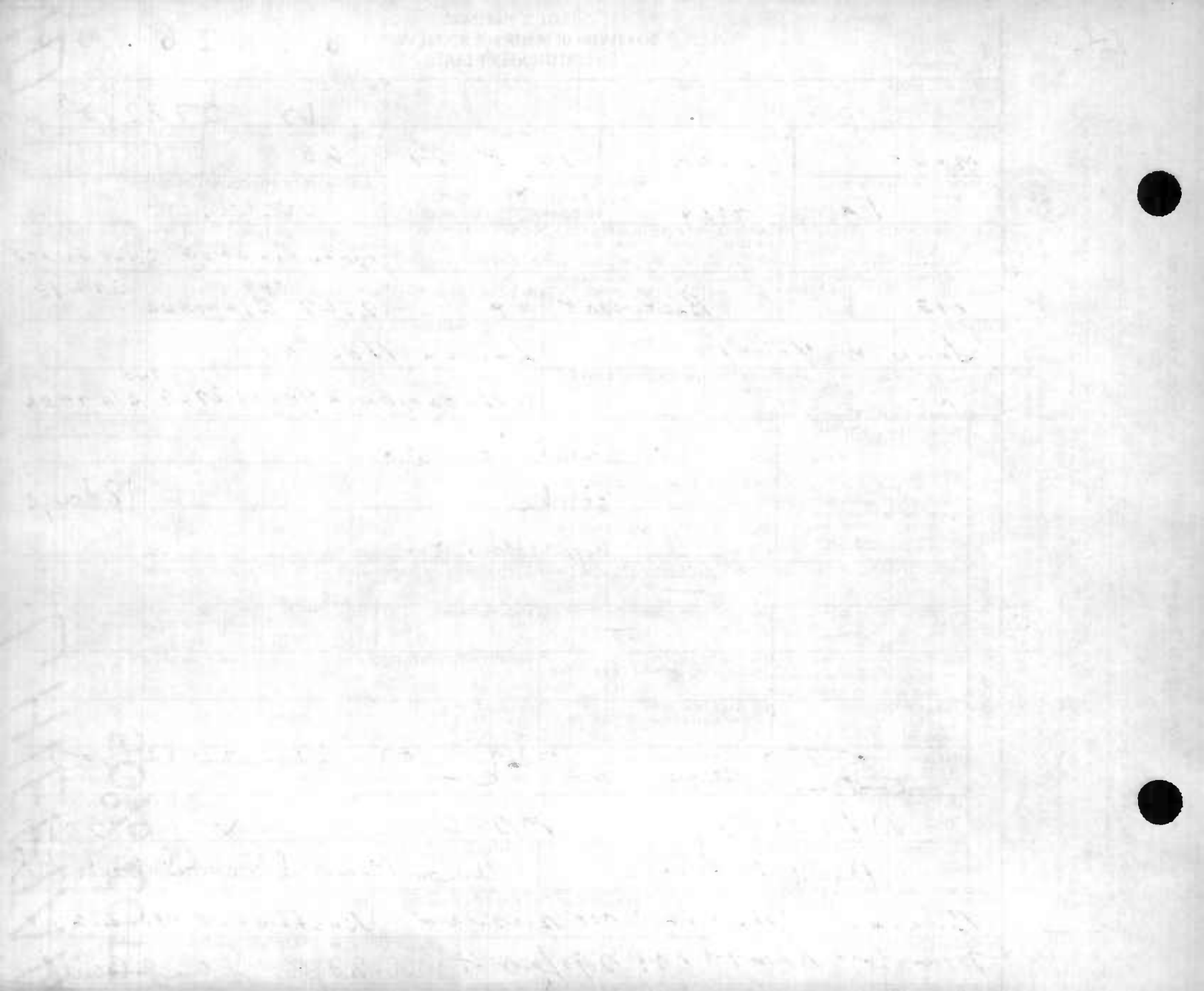
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 27 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 4 0 3	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) JOHN W. YOUNG						2a. DATE OF DEATH MONTH DAY YEAR 10 27 82			2b. HOUR 215 M		
1. SEX MALE		4. RACE BLACK		5. DATE OF BIRTH MONTH DAY YEAR 10 5 14		6. AGE (IN YEARS LAST BIRTHDAY) 68 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) PA.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH BALTIMORE, CITY MD.					
10. CITY OR TOWN OF DEATH BALTIMORE		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) UNION MEMORIAL HOSPITAL				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) MAINTENANCE			12b. KIND OF BUSINESS OR INDUSTRY REPAIRS		
13a. STATE MD		13b. COUNTY BALTIMORE		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 2769 ALAMODA 21218					
14. FATHER'S NAME FIRST MIDDLE LAST John W Young				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Laura Holley							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES)		17. INFORMANT ADDRESS WILHELMENIA YOUNG 2769 ALAMODA							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral herniation</u> 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>stroke</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>hypertension</u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 days											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: <u>—</u>											
19a. DATE OF OPERATION —		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED —				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21i. LOCATION STREET		CITY OR TOWN		COUNTY		STATE	
22a. I certify that <u>he</u> (this hospital) attended the deceased from <u>10/19</u> 19 <u>82</u> to <u>10/27</u> 19 <u>82</u> , that <u>he</u> (we) last saw the deceased alive on <u>10/26</u> 19 <u>82</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (If <u>we</u> (did) <u>did not</u> view the body after death.											
22b. SIGNATURE D M Riffley				DEGREE MD				ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/27/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) David M Riffley				22e. ADDRESS Union Memorial Hospital Baltimore							
23a. BURIAL, CREMATION, REMOVAL (IF OTHER)		23b. DATE 11-1-82		23c. NAME OF CEMETERY OR CREMATORY Mt Auburn		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore MD 21230					
24. FUNERAL DIRECTOR NAME Mansoor A. Harris 638 091/mor st				25a. DATE REC'D. BY REGISTRAR OCT 29 1982		25b. REGISTRAR'S SIGNATURE John J. Canine					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 6 4 0 4 REG. NO.			
1. FOR STATE REGISTRAR							
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lillian Ida Young				2a. DATE OF DEATH MONTH DAY YEAR October 26, 1982		2b. HOUR 9 AM	
3. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR Aug. 30, 1902		6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 80	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md.		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Maltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET "DOOR") Long Green Nursing Home		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY	
13a. STATE Maryland		13b. COUNTY Baltimore		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET ADDRESS 3235 Shannon Drive	
14. FATHER'S NAME FIRST MIDDLE LAST Henry Miller				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Caroline Baer			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-05-4716B		17. INFORMANT ADDRESS William H. Harrison 6215 Falls Rd. 21209			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Vasculature accident 4360 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) Cerebral Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Generalized A-S APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hrs. 3 hrs. 10 hrs.							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: a							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (I) (the hospital) attended the deceased from 10/12/82 to 10/26/82 that (I) (we) last saw the deceased alive on 10/12/82 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.							
22b. SIGNATURE Norman R. Freeman MD DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>						22c. DATE SIGNED 10/27/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) NORMAN R. FREEMAN						22e. ADDRESS 11 W. 29th St.	
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 29, 1982		23c. NAME OF CEMETERY OR CREMATORY Parkwood		23d. LOCATION CITY OR TOWN COUNTY STATE Parkville, Balto. Co., Md.	
24. FUNERAL DIRECTOR NAME ADDRESS Mitchell-Wiedefeld Home, Inc. Balto., Md. 21212				25. DATE REC'D. BY REGISTRAR REGISTRAR'S SIGNATURE NOV 3 1982 John J. Conish			

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11-3-71 Bill Garrison 11-3-71

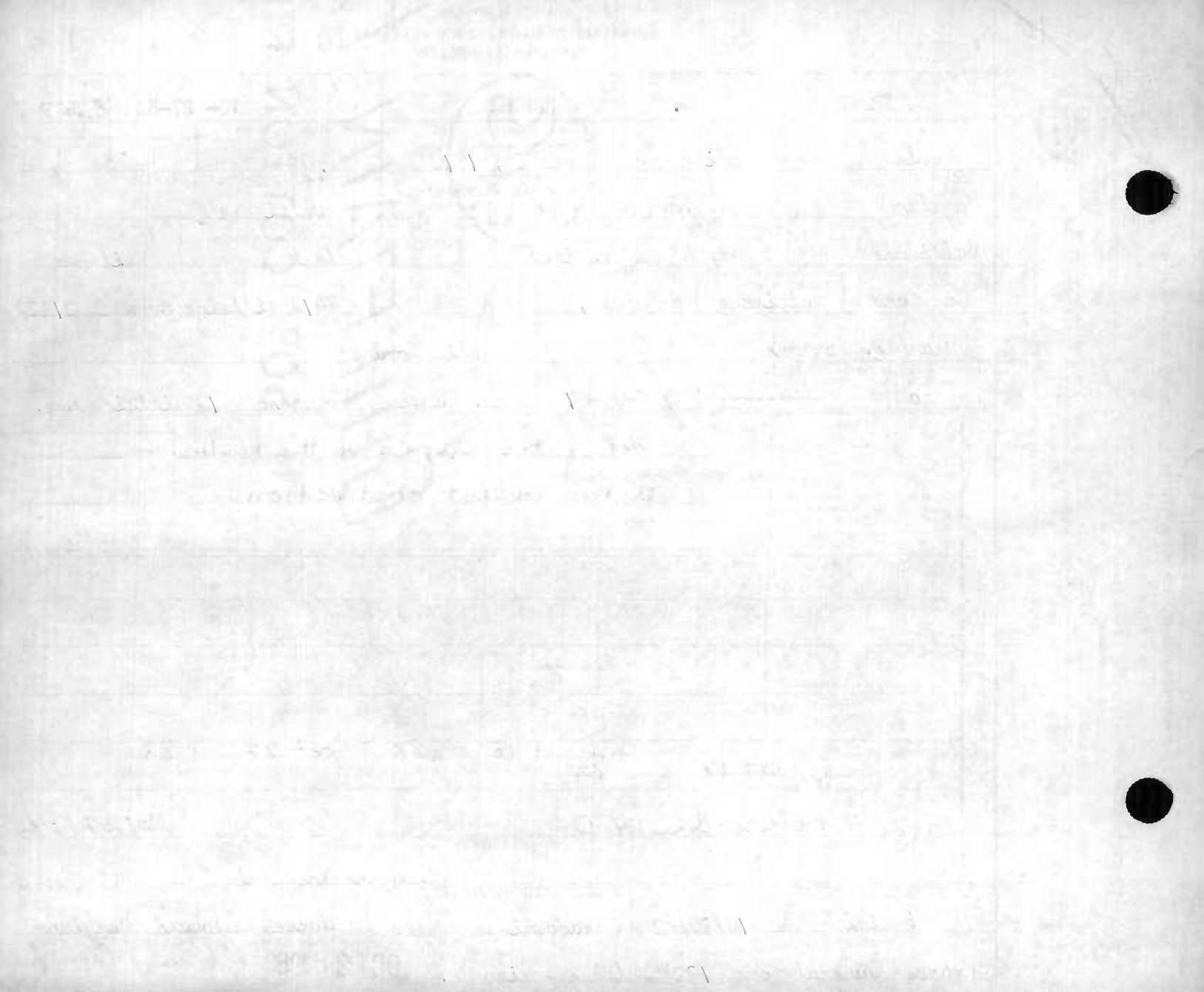
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers, Pages 1 and 2, and 2 should be filed within 22 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 4 0 5 REG. NO.			
1. FOR STATE REGISTRAR													
I. DECEASED NAME (TYPE OR PRINT) FRANK W. YOUNGER					2a. DATE OF DEATH MONTH DAY YEAR 10-27-82					2b. HOUR 8:00 P M			
3. SEX male		4. RACE white		5. DATE OF BIRTH MONTH DAY YEAR Feb 24, 1912		6. AGE (IN YEARS (LAST BIRTHDAY)) 70 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) clerk		12b. KIND OF BUSINESS OR INDUSTRY railroad					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland		13b. COUNTY Baltimore		13c. CITY OR TOWN Arbutus		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS 4410 Hillside Avenue 21229					
14. FATHER'S NAME FIRST MIDDLE LAST Frank W. Younger					15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Katie Romans								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 705-05-6104		17. INFORMANT Mrs. Naomi M. Younger		ADDRESS 4410 Hillside Ave.							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1541 IMMEDIATE CAUSE (a) Metastatic Ca, Ca of the rectum. DUE TO, OR AS A CONSEQUENCE OF (b) gastric outlet obstruction. DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME STREET FACTORY OFFICE FARM ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from August 18, 1982 , to Oct 27, 1982 , that (I) (we) lost saw the deceased alive on Oct 27, 1982 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b. SIGNATURE Faiz M. Belwadi, M.D.				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>				22c. DATE SIGNED 10/27/82					
22d. PHYSICIAN'S NAME (TYPE OR PRINT)				22e. ADDRESS St. Agnes Hospital									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial		23b. DATE 10/30/82		23c. NAME OF CEMETERY OR CREMATORY Meadowridge Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Dorsey Howard Maryland							
24. FUNERAL DIRECTOR NAME Ambrose Funeral Home				ADDRESS 1328 Sulphur Spring Rd.		25a. DATE REC'D. BY REGISTRAR OCT 28 1982		25b. REGISTRAR'S SIGNATURE Joan J. Conner					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH				8 2 2 6 4 0 6 REG. NO.			
1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST CHARLES CYRIL ZARUBA Sr.				2a. DATE OF DEATH MONTH DAY YEAR 10 14 82			
3. SEX MALE		4. RACE WHITE		5. DATE OF BIRTH MONTH DAY YEAR 9 29 13		6. AGE (IN YEARS LAST BIRTHDAY) IF UNDER 1 YEAR IF UNDER 24 HRS. 69 YRS. MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD.	
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) St. Agnes Hospital		12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Shipfitter		12b. KIND OF BUSINESS OR INDUSTRY Coast Guard	
13a. STATE Maryland				13b. COUNTY Baltimore		13c. CITY OR TOWN Baltimore	
14. FATHER'S NAME FIRST MIDDLE LAST Karel ----- Zaruba				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annastasia ----- Becvar			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No		16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-05-6420		17. INFORMANT ADDRESS Mrs. Mary F. Zaruba, Same as above			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiorespiratory Arrest. 4149 DUE TO, OR AS A CONSEQUENCE OF (b) Coronary artery disease DUE TO, OR AS A CONSEQUENCE OF (c) 2							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Diabetes Mellitus							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)			
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE			
22a. I certify that (this hospital) attended the deceased from 10/04/1982 to 10/14/1982 , that (we) lost saw the deceased alive on 10/14/1982 , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.							
22b. SIGNATURE B. K. SINHA				DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/>		22c. DATE SIGNED 10/14/82	
22d. PHYSICIAN'S NAME (TYPE OR PRINT) B. K. SINHA				22e. ADDRESS ST. AGNES HOSPITAL, BALTIMORE MD.			
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE Oct. 18, 1982		23c. NAME OF CEMETERY OR CREMATORY Holy Cross Cemetery		23d. LOCATION CITY OR TOWN COUNTY STATE Baltimore, Maryland	
24. FUNERAL DIRECTOR NAME ADDRESS McCully Funeral Home, 4200 Pennington Ave. Balto. Md. 21226				25a. DATE REC'D. BY REGISTRAR OCT 19 1982		25b. REGISTRAR'S SIGNATURE John J. Conish	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 4 0 7	
1. FOR STATE REGISTRAR		REG. NO.									
1. DECEASED NAME (TYPE OR PRINT) <i>Annie Zemel</i>						2a. DATE OF DEATH MONTH DAY YEAR <i>10 22 82</i>		2b. HOUR <i>9 PM</i>			
3. SEX <i>FEMALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH MONTH DAY YEAR <i>1 23 1894</i>		6. AGE (IN YEARS LAST BIRTHDAY) <i>88</i>		7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>POLAND</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH <i>BALTIMORE CITY, MD.</i>					
10. CITY OR TOWN OF DEATH <i>BALTIMORE</i>		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>REINDALE GERIATRIC HOSP</i>				12a. USUAL OCCUPATION (TYPE OF BUSINESS OR WORKING LIFE) <i>XXXXXX</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>AT HOME</i>			
13a. STATE <i>MARYLAND</i>		13b. COUNTY <i>BALTO</i>		13c. CITY OR TOWN <i>BALTIMORE</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET ADDRESS <i>4 RUSSERN CT., APT. 1C #21215</i>			
14. FATHER'S NAME FIRST MIDDLE LAST <i>ABRAHAM WEINER</i>				15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>HANNAH UNKNOWN</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>NO</i>		16b. SOCIAL SECURITY NO. <i>217-32-7603</i>		17. INFORMANT <i>MR. ARNOLD WEINER</i> <i>8201 SPRING BOTTOM WAY #21208</i>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: <i>1579 Multiple Myeloma Involving</i> <i>Cancer of the Pancreas</i> IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>Months</i>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR <i>19</i>		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)							
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE							
22a. I certify that (I) (this hospital) attended the deceased from <i>9/20/82</i> 19 <i>82</i> , to <i>10/22/82</i> 19 <i>82</i> , that (we) last saw the deceased alive on <i>10/22/82</i> 19 <i>82</i> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (a) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Noel David List</i>		DEGREE <i>M.D.</i>		ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>				22c. DATE SIGNED <i>10/22/82</i>			
22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>NOEL DAVID LIST</i>		22e. ADDRESS <i>GREENSPRING BELVEDERE #21208</i>									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>BURIAL</i>		23b. DATE <i>10-24-82</i>		23c. NAME OF CEMETERY OR CREMATORY <i>SWINICHER WOLINER BENEVOLENT ASSOC.</i>		23d. LOCATION CITY OR TOWN COUNTY STATE <i>BALTIMORE MD</i>					
24. FUNERAL DIRECTOR <i>SOL LEVINSON & BROS., INC.</i> NAME <i>6010 REISTERSTOWN RD., BALTO., MD 21215</i>						25. DATE REC'D. BY REGISTRAR (31) REGISTRAR'S SIGNATURE <i>John J. [Signature]</i>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be joined by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 states any injury, or other traumatic event, the medical examiner must be notified.

STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH										8 2 2 6 4 0 8			
FOR 1 - STATE REGISTRAR										REG. NO.			
1. DECEASED NAME (FIRST OR PRINT) KATHERINE ESTELLA ZIGAS					2a. DATE OF DEATH MONTH DAY YEAR 10 9 82					2b. HOUR 12 15 P.M.			
1. SEX Female		4. RACE White		5. DATE OF BIRTH MONTH DAY YEAR NOV. 16 1897		6. AGE (IN YEARS LAST BIRTHDAY) 84		IF UNDER 1 YEAR MONTHS DAYS YRS		IF UNDER 24 HRS. HOURS MIN. MIN.			
7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. BALTIMORE CITY OR COUNTY OF DEATH Baltimore City MD							
10. CITY OR TOWN OF DEATH Baltimore		11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN BALTIMORE CITY, GIVE STREET ADDRESS) SOUTH BALTIMORE GENL. HOSP.				12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Homemaker		12b. KIND OF BUSINESS OR INDUSTRY Own Home					
13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE Maryland				13c. CITY CITY		13d. CITY OR TOWN Baltimore		13e. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13f. STREET ADDRESS 4201 Morrison Court			
14. FATHER'S NAME Mark Preston Harrison				15. MOTHER'S MAIDEN NAME Josephine Benton				ADDRESS Pasadena, Md.					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO		16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) N/A		17. INFORMANT Mrs. Ruth C. Matt (Daughter)		ADDRESS 2122							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardio Respiratory Arrest. 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Severe Congestive Heart Failure. (c) ASCVD										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a) Functional Abdominal Bowel obstruction.													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 9 19		21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.)		21f. LOCATION STREET CITY OR TOWN COUNTY STATE									
22a. I certify that (I) (this hospital) attended the deceased from 9/7 19 82 to 10-9 19 82 , that (I) (we) last saw the deceased alive on 10/9/82 19 82 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. If (we) (did) (did not) view the body after death.													
22b. SIGNATURE Heather Silva, MD				DEGREE				22c. DATE SIGNED 10/9/82					
22d. PHYSICIAN'S NAME (TYPE DEGREE) H. SILVA				22e. ADDRESS 301 S HANOVER ST BALTO MD									
23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial		23b. DATE 12 OCT '82		23c. NAME OF CEMETERY OR CREMATORY Glen Haven Mem.Pk.		23d. LOCATION CITY OR TOWN COUNTY STATE Glen Burnie A.A. Md.							
24. FUNERAL DIRECTOR NAME Dem. P. Charlton ADDRESS						25a. DATE REC'D. BY REGISTRAR		25b. REGISTRAR'S SIGNATURE John J. Conner					
SINGLETON FUNERAL HOME, GLEN BURNIE, MD OCT 11 1982													

STELLA 2100

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

82 26409

REG. NO.

1. DECEASED NAME (TYPE OR PRINT) **LOUIS ZIRLIN**

2a. DATE OF DEATH MONTH **10** DAY **20** YEAR **82** 2b. HOUR **5:47 PM**

3. SEX **MALE** 4. RACE **WHITE** 5. DATE OF BIRTH MONTH **9** DAY **7** YEAR **04** 6. AGE (IN YEARS LAST BIRTHDAY) **78** YRS. IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.

7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) **RUSSIA** 7b. CITIZEN OF WHAT COUNTRY? **USA** 8. MARRIED ☒ NEVER MARRIED ☐ WIDOWED ☐ DIVORCED ☐ 9. BALTIMORE CITY OR COUNTY OF DEATH **BALTO CITY** MD.

10. CITY OR TOWN OF DEATH **BALTO.** 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) **SINAI HOSPITAL** 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) **SALESMAN** 12b. KIND OF BUSINESS OR INDUSTRY **INSURANCE**

13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE **MD** 13c. CITY OR TOWN **BALTO.** 13d. INSIDE CITY LIMITS? YES ☒ NO ☐ 13e. STREET ADDRESS **APT. 414 #21210 1190 W. NORTHERN PARKWAY**

14. FATHER'S NAME FIRST **ISAAC** MIDDLE LAST **ZIRLIN** 15. MOTHER'S MAIDEN NAME FIRST **YETTA** MIDDLE LAST **GLUSKIN**

16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES OR UNKNOWN) **NO** (IF YES, GIVE WAR OR DATES) 16b. SOCIAL SECURITY NO. **213-03-8426** 17. INFORMANT **MRS. ANN ZIRLIN** APT. 414 **1190 W. NORTHERN PKWY.** #21210

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) **4274 Hypotension**
DUE TO, OR AS A CONSEQUENCE OF (b) **Ventricular Failure**
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. }
DUE TO, OR AS A CONSEQUENCE OF (c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

19a. DATE OF OPERATION 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 19c. AUTOPSY? YES ☐ NO ☒ 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES ☐ NO ☐ (RT 2)

20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 **10/20** 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1) OR F

21a. INJURY OCCURRED 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) 21c. LOCATION STREET CITY OR TOWN COUNTY STATE

22a. I certify that (I) (this hospital) attended the deceased from **10/20** 19 **82** to **10/20** 19 **82** and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did not) view the body after death. SIGNED **10/20/82**

22b. SIGNATURE **A. Hettlerman** DEGREE ATTENDING PHYSICIAN ☐ MEDICAL DIRECTOR ☐ STAFF PHYSICIAN ☒ 22c. DATE **10/20/82**

22d. PHYSICIAN'S NAME (TYPE OR PRINT) **A. Hettlerman** 22e. ADDRESS **SINAI HOSPITAL**

23a. BURIAL, CREMATION, REMOVAL (SPEC) **BURIAL** 23b. DATE **OCT. 22, 1982** 23c. NAME OF CEMETERY OR CREMATORY **BNAI ISRAEL** 23d. LOCATION CITY OR TOWN COUNTY STATE **BALTIMORE MARYLAND**

24. FUNERAL DIRECTOR **SOL LEVINSON & BROS., INC.** 24b. NAME ADDRESS **6010 REISTERSTOWN RD. BALTO., MD 21215** 25a. DATE REC'D. BY REGISTRAR **OCT 22 1982** 25b. REGISTRAR'S SIGNATURE **John J. Conner**

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